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Mental illness, recovery, and employment: A grounded theory

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**MENTAL ILLNESS, RECOVERY AND EMPLOYMENT: A GROUNDED
THEORY**

by
Francine M. Bates

A Dissertation

Submitted to the
Department of Educational Services and Leadership
College of Education
In partial fulfillment of the requirement
For the degree of
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at
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Dissertation Advisor: Barbara Bole Williams, Ph.D.

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Dedications

I would like to dedicate this manuscript to my parents Stephen and Cecilia Cermak who instilled in me the love of education.

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Abstract

Francine M. Bates
MENTAL ILLNESS, RECOVERY AND EMPLOYMENT: A GROUNDED THEORY
2018-2019
Barbara Bole Williams, Ph.D.
Doctor of Education

This grounded theory study provides knowledge about the persistent unemployment of individuals in recovery from serious mental illness (SMI) who additionally receive supplemental security disability benefits (SSI). A constructivist framework was used in the development and implementation of this study. Grounded theory methods for data coding and analysis consisted of initial, focused and theoretical coding. Analysis continued in the development of theoretical concepts and emergent theory. Findings emphasize the complexity and amalgamation of the lived experiences of study participants that sustain unemployment. Theoretical concepts presented in this study are, composite barrier, encumbering reality, the obstructing impact of ambivalence, and the someday dream of inaction. Discussion of these concepts and development of a substantive theory explains the enduring unemployment of individuals in recovery from SMI who receive SSI.

Table of Contents

Abstract	v
List of Figures	xi
List of Tables	xii
Chapter 1: Introduction	1
Problem Statement	4
Purpose Statement and Research Questions	5
Significance of the Study	6
Future Studies	8
Conclusion	9
Chapter 2: Literature Review	10
Defining Serious Mental Illness	11
Serious Mental Illness-Recovery	12
Principles of Recovery	13
Benefits of Employment	14
High Unemployment for Individuals with Serious Mental Illness	15
Functional Limitations That Impact Employment	16
Educational and Work Deficits	17
Lack of Effective Services	17
Impact of Poverty	19
Labor Market Impact	20
Legislation	21
Supplemental Security Income	21

Table of Contents (Continued)

Eligibility for SSI.....	21
Social Security Work Incentives.....	22
Conclusion	23
Chapter 3: Methods.....	25
Assumptions of and Rationale for Qualitative Inquiry	26
Grounded Theory as a Strategy of Inquiry	27
Theory Development	27
Sampling	28
Sampling Criteria.....	29
Context.....	29
Recruitment Protocol	30
Data Collection	31
Informed Consent Protocol.....	31
Demographic Protocol	31
Recovery Scale Protocol.....	32
Interview Protocol.....	32
Memo Writing Protocol	33
Instrumentation	33
Data Analysis	35
Coding.....	35
Data Interpretation	38
Rigor of Study Design	39

Table of Contents (Continued)

Reflexivity.....	42
The Role of the Researcher.....	43
Researcher Biases	44
Ethical Considerations	44
Protection of Participants	45
Individuals with Mental Illness.....	46
Sensitivity of the Subject Matter.....	46
Power Issues.....	47
Conclusion	47
Chapter 4: Findings.....	49
Profile of Participants	50
Data Collection	53
Data Analysis	54
Coding.....	55
Results of Analysis	57
Recovery	57
So Many Barriers	62
Ambivalence	67
Employment Supports.....	71
Answering Second Level Research Questions	73
Explaining Enduring Unemployment, Theory Development	74
Composite Barrier.....	74

Table of Contents (Continued)

Encumbering Reality	77
Obstructing Impact of Ambivalence.....	78
Someday Dream of Inaction	79
Conclusion	79
Research Question 1	80
Research Question 2	80
Research Question 3	81
Research Question 4	81
Research Question 5	82
Overarching Research Question	82
Chapter 5: Discussion, Recommendations, Implications, and Conclusions.....	83
Importance of Research	84
Discussion of Findings as Situated in the Literature	84
Recovery	85
So Many Barriers	87
SSI's Impact on Employment	89
Ambivalence	90
Employment Supports	91
Emergent Theory	93
Researcher Assumptions and Biases	93
Limitations	95
Follow Up and Modifications	96

Table of Contents (Continued)

Implications of the Theoretical Framework	97
Constructivism	98
Critical Disability Theory	98
Achieving Research Aims	98
Implications of Findings	99
Implications for the Field of Mental Health	99
Implications for State and Federal Government	101
Personal Implications	102
Conclusion	105
References	107
Appendix A: Permission to be Contacted for Research Study	123
Appendix B: Advertisement Flyer	124
Appendix C: Informed Consent	125
Appendix D: Demographics Intake Questionnaire	127
Appendix E: Participant Recovery Scale (PRS)	128
Appendix F: Interview Questionnaire	129
Appendix G: Initial Codes	132
Appendix H: Focused Codes	136
Appendix I: Focused Codes Answering Research Questions	139

List of Figures

Figure	Page
Figure 1. Data Collection and Analysis, Initial and Focused Coding.....	36
Figure 2. Theoretical Coding and Analysis	37
Figure 3. Theoretical Matrix	76

List of Tables

Table	Page
Table 1. Research Questions in Relation to Interview Questions.....	34
Table 2. Code Mapping: Three Iterations of Analysis.....	41
Table 3. Ethnicity, Age, Education, Diagnosis, Employment	51
Table 4. Age and Years Since Last Job Means, Job Tenure Median.....	52
Table 5. Second Iteration of Focused Codes	56
Table 6. Multiple Barriers.....	64
Table 7. Code Mapping: Three Iterations of Analysis to Answer Research Questions ..	75

Chapter 1

Introduction

Having a serious mental illness (SMI) can be devastating, affecting every aspect of a person's life—mental, physical, spiritual, social, and economic. Fortunately, serious mental illnesses are treatable. With a combination of ever-improving medications, rehabilitation services, and advocacy efforts, the vast majority of individuals in recovery from SMI live independently in the community of their choice (Davidson & Roe, 2007; NAMI Mental Illness [NAMI], 2018). Yet, the majority remains unemployed, underemployed, or marginally employed (Bazelon, 2014; Bond, 2004; Henry, Barkoff, Mathis, Lilly, & Fishman, 2016; McQuilken et. al., 2003; NAMI, 2014a). Mental illness, recovery, and sustained unemployment are the focus of this study.

Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning, and usually strike during adolescence or young adulthood (Kessler, Berglund, Demler, Jin, & Walters, 2005; Kessler, Chiu, Demler, & Walters, 2005; McAlpine & Warner, 2002; NAMI, Mental Illness, 2018; National Institute on Mental Health [NIMH], 2017). Individuals with SMI are a diverse group. SMI is not a respecter of race, ethnicity, gender, social class, age, or sexual orientation. SMI diagnoses include major depressive disorder, schizophrenia, schizo-affective disorder, bipolar disorder, and obsessive-compulsive disorder (OCD) (APA, 2013), and impact about 4.2% of the population—in 2016 that was 10.4 million American adults (NIMH, 2017). Without treatment SMI affects the individual, family, community, and society as a whole. Unnecessary impairment, homelessness, inappropriate-incarcerations, and unemployment are but a few consequences of not

receiving treatment. The economic cost of lost wages alone in the United States (U.S.) is almost 200 billion dollars annually (Insel, 2008, 2011; Kessler, et al., 2008). Fortunately, a service delivery transformation movement recognizes that recovery from mental illness is becoming a reality for many (Halal & Graf, 2004; NJDMHAS, 2007; President's New Freedom Commission on Mental Health, 2003).

A definition of recovery continues to evolve as treatment, rehabilitation services, and advocacy efforts combine to improve the lives of individuals with SMI (Andresen, Oades, & Caputi, 2003, 2011; Davidson & Roe, 2007; NAMI, 2018; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). With effective treatment, the majority of individuals with SMI experience reduced symptoms, an improved quality of life, and renewed hope of recovery (NAMI, 2018; Davidson & Roe, 2007). Highly effective treatments include a combination of pharmacological and psychosocial treatments and support. Newer psychotropic medications are better able to eliminate or reduce symptoms (NAMI, Mental Health Treatment, 2018; NAMI, Mental Health Medication, 2017; NIMH, Mental Health Medications, 2016). Yet, even with new medications, and improved rehabilitative services, the majority of individuals with SMI remain unemployed.

One contributing factor may be the lag in implementation of recovery practices by mental health providers. Historically, the U.S. mental health system has discouraged people with MI from working (Marrone & Golowka, 1999). A belief that the stress of work leads to relapse, and that work is not worth the risk, persists (Henry et al., 2016) despite extensive research that does not support these beliefs. Work has been shown to increase self-esteem, provide a valued social role and identity, lessen symptoms, and

improve finances (Dunn, Wewiorski, & Rogers, 2008; Dunstan, Falconer, Price, 2017; Evans, Repper, 2000; Swarbrick, 2006). However, individuals with MI who have spent years in mental health programs find themselves with long-standing unemployment, missed opportunities, and unprepared to compete with more qualified applicants in an already strained job market. The mental health system in the U.S. is slowly changing, and hopefully will better serve younger individuals to prevent years of living in poverty, isolation, and unemployment (Marrone & Golowka, 1999).

Unemployment rates for individuals with MI are significantly higher than the unemployment rates for individuals with other disabilities (Henry, et al., 2016; Mechanic, Bilder, & McAlpine, 2002; Mueser, Salyers, & Mueser, 2001; Perkins & Rinaldi, 2002; Zwerling et al., 2002), or for people without disabilities (Bazelon Center, 2014; Bureau of Labor Statistics [BLS], 2018; World Health Organization [BLS], 2018). The unemployment rate is believed to be an abysmally high 60-90% (NASMHPD, 2007; SAMSHA, 2012).

Significant factors influencing this unemployment rate include limited education, interrupted careers, and labor market liabilities, such as a lack of social connections, driver's license (Baron & Salzer, 2002), and the disincentives associated with the Social Security disability system (McQuilken, et. al., 2003; MacDonald-Wilson, Rogers, Ellison, & Lyass, 2003). Additionally, symptoms and medication side effects (McAlpine, & Warner, 2004) may be ongoing, and more difficult to control soon after diagnosis (Falloon, Kydd, Coverdale, & Laidlaw, 1996) or with poor treatment (Wang, et al., 2005; Shim, Compton, Rust, Druss, & Kaslow, 2009).

Fortunately, eligibility for permanent federal disability income is available when symptoms of MI are severe enough that functional ability makes work impossible. Of interest in this study is the continued unemployment of individuals in recovery from mental illness who are on Supplemental Security Income (SSI), one of the Social Security Administration's (SSA) disability programs. Approximately 31% of SSI recipients between the ages of 18 and 59 qualify for SSI due to a mental illness (Social Security Administration [SSA], 2017). Most research studying the impact of permanent disability benefits on employment include participants of both federal SSA disability programs, SSI and Social Security Disability Insurance (SSDI). Each of these programs has different eligibility requirements, potential benefit allowances, and work incentives. Individuals receiving SSI inherently have less work history and fewer assets than individuals receiving SSDI. By parsing out SSI a deeper understanding of the impact of this disability program can be garnered.

Problem Statement

Individuals with mental illness are one of the most marginalized and callously stigmatized groups of people (Baldwin, & Marcus, 2007; Johnstone, 2001; Kreek, 2011; Morgan, Burns, Fitzpatrick, & Priebe, 2007; Thornicroft, Brohan, Rose, Sartorius, & Leese, 2009; Waghorn & Lloyd, 2005; World Health Organization [WHO], n.d.). Consequently, they are feared, severely misunderstood, ridiculed, called by derogatory names, and are denied participation in many communities, e.g., housing. Unemployment and poverty further exacerbate a person's marginalization and inequitable treatment (Mural & Oyebo, 2004; Weich & Lewis, 1998). Without the advantage of working in a job making a living wage (Glasmeier & MIT, 2013)—making enough to support one's

self—individuals with SMI are most often left to a life of poverty and dependence on governmental support (Baron & Salzer, 2002; Marrone & Golowka, 1999), which provides a monthly benefit below the federal poverty level (Danziger, Franck & Meara, 2009; SSA, 2018).

While individuals with MI living on SSI are not left without sustenance, a social justice issue is evident. Two U.S. policy areas contribute to the social injustice. First, is the absence of workforce development policies that create more living wage jobs for individuals who do not have the prerequisites, and may not be able to attain these requisites, for high paying or professional jobs (Baron & Salzer, 2002). Most fundamentally, these prerequisites include advanced education and skills, and expanded social networks. The second policy area is the SSA disability system, which provides low level sustenance in time of need but perpetuates long-term dependency as well. Acceptance of U.S. policies that tolerate poverty, and provide limited opportunities to escape from poverty, need to change.

Purpose Statement and Research Questions

The purpose of this study is to develop a grounded theory of the process that leads to enduring unemployment of individuals in recovery from MI and receiving SSI. The following research questions were developed to explore, understand, and expound this theory.

1. What is the process that leads to continued unemployment of individuals in recovery from mental illness?
2. What factors identified by individuals in recovery from mental illness contribute to their unemployment?

3. How does paid employment fit into the definition of recovery for individuals in recovery from mental illness?
4. How do individuals in recovery from mental illness make the decision to work or remain unemployed?
5. From the perspective of individuals in recovery from mental illness, what needs to happen for them to choose employment?

Grounded theory research methods were used beginning with semi-structured, in depth interviews. The semi-structured interview gathered data about the lived experience of having MI, how this lived experience has led to long-term unemployment, and how employment fits into individual definitions of recovery. Interview data was transcribed, coded using constant comparison, and analyzed. Emerging concepts and relationships of concepts were identified and theory developed. A diagram representing the process that leads to sustained unemployment of study participants was constructed to exemplify theory explaining this process.

The sample consists of 15 individuals with a major MI (major depressive disorder, schizophrenia, bi-polar disorder or schizo-affective disorder), who are presently unemployed and receiving SSI benefits. Additionally, demographic data was gathered to identify gender, age, diagnosis, and work history. Participants self-identified as being in recovery with the additional criterion of one year or longer with no hospitalization for MI treatment.

Significance of the Study

Working-aged Americans with disabilities are more likely to live below the current poverty line compared to those who do not have disabilities. The U. S. Census

Bureau (2017) provides percentages of individuals living in poverty at 26.8% with a disability vs 10.9% without a disability. Additionally, individuals with disabilities are twice as likely to go further into debt each month than those without a disability (LEAD Center, 2016). The 2018 federal poverty guideline for a single-family household in the 48 border states is \$12,140/year (Department of Health and Human Services [DHHS], 2018) or \$1,012 per month. The 2018 SSI payment for an individual is \$9,000/year or \$750 per month (SSA, Security Online, 2018; SSA, SSI Federal Payment Amounts 2018), and is designed to maintain people at some minimal standard of living (Halloran, 1991). Some states additionally supplement this federal rate, raising monthly payments of SSI recipients. State supplements range from \$10 to \$400; eight states offer no additional supplement (Laurence, 2018). Even with these state SSI supplements, individuals receiving SSI live at or below the poverty level.

Several constituencies may benefit from the results of this study, including rehabilitation and clinical professionals, U.S. and state policy makers, and ultimately individuals with SMI. Most rehabilitation and clinical professionals have never experienced SMI, never collected SSI, and are not in the process of recovery from SMI. This differing lived experience (Warner & Polak, 1995) limits understanding of the processes underlying employment decisions made by individuals recovering from SMI. Decisions regarding work are not always seen as logical or judicious by mental health professionals (Warner & Polak, 1995; Quadagno, 1997). Having a greater comprehension of the underlying factors will enable practitioners to better assist persons with SMI in employment decision making, acquisition, and maintenance. Development

of theory that explains the process of continued unemployment will aid in this understanding.

The broadest area with significance to this study and bearing on the enduring unemployment of individuals in recovery from MI is SSI dependency due to perceived or real work disincentives (Baron & Saltzer, 2002; McDonald-Wilson et al., 2003).

Ticket to Work and Work Incentive Improvement Act (TWWIA) of 1999 (SSA, 1999) eased some of the disincentives in returning to work for individuals on SSI. Yet, additional work-incentive legislation and improvement to the SSA system as a whole are needed to diminish the remaining work-disincentives inherent in the SSA system. Notable concerns are a sluggish bureaucratic system that affects reinstatement of cash benefits if a person becomes ill again, and the steep decline of food stamps allotment and housing subsidy once a person begins receiving earned income (Halloran, 1991; McDonald-Wilson et al., 2003). Further understanding of how SSI impacts employment decisions of individuals with SMI may well assist in conscientious changes in U.S. policy, providing increased financial stability to these individuals.

Future Studies

Additional studies may be supported by the results of this study's findings. A related study can explore the high unemployment rate of individuals with SMI who are collecting SSDI—a federal disability program available for individuals who have a significant enough work history and have paid into this program. Exploration of potential solutions to causes of unemployment, as identified by individuals with a psychiatric disability receiving SSI or SSDI, would be a compelling study as well.

A theory conceiving the process that leads to the high unemployment rates of individuals with SMI collecting SSI is only the beginning of addressing the issue of continued unemployment of individuals recovering from SMI. Other questions include, Are mental health professionals aware of what programs will best serve individuals on SSI? Are policy makers aware of what changes in policies will best assist in improving employment outcomes? Individuals who are directly impacted by policies and program services are best suited to address solutions to identified barriers and should be included more fully in future research, policy, and mental health service delivery decisions.

Conclusion

This study developed a theory explaining the process that leads to enduring unemployment of individuals in recovery from SMI. It specifically, addresses those receiving SSI benefits due to SMI. Most research addressing SSA and its impact on employment lump both SSI and SSDI together. This study parses out SSI to gain a better understanding of its unique eligibility requirements and work incentives. Eligibility for SSI identifies beneficiaries' limited work history and limited financial assets, both potentially contributing to the enduring unemployment of individuals in recovery from SMI receiving SSI.

Involvement in a public mental health system and being a Social Security beneficiary are not sufficiently addressed by general career and vocational theories. A theory that incorporates these factors, expressed from the perspective of the individuals in recovery may be useful to understanding the unique employment decision making process of individuals in recovery from SMI.

Chapter 2

Literature Review

In 2016, over 10.4 million adults, or around 6 percent, had what is considered a serious mental illness (SMI) (NIMH, 2017). Without successful treatment and recovery, the consequences of SMI for the individual and society are staggering. In addition to disabling symptoms, SMI can result in years of unemployment, dependency, poverty, homelessness, inappropriate incarceration, and isolation (Marrone & Golowka, 1999). The damaging effects of these consequences become as devastating as the illness itself, preventing adequate housing, income and, health care (Wang et al., 2005).

Fortunately, a newer generation of medications and the growth of psychiatric rehabilitation are improving the lives of those living with SMI. Wellness and recovery are becoming realities (Davidson & Roe, 2007), and acceptance of recovery concepts can be seen in both state (NJDMHAS, 2007, 2012) and federal support and legislation (President's New Freedom Commission on Mental Health, 2003). Regrettably, the exorbitantly high unemployment rates and a life of poverty for individuals in recovery from SMI persist.

Many factors contribute to this high unemployment rate including symptoms, medication side effects, poor work history, and stigma (Barron & Salzer, 2002; Cook, 2006; Johannesen, McGrew, Griss, & Born, 2009; McAlpine & Warner, 2002). Whatever the reason, the lack of earnings makes receipt of disability benefits a necessity. Unfortunately, disability programs that are in place to support people when they are unable to work sometimes become barriers themselves. (McDonald-Wilson et al., 2003).

Of interest to this study are the contributing factors of the enduring unemployment rate of individuals with SMI, even when they are in recovery.

The purpose of this study was to develop a grounded theory explaining the phenomenon of high unemployment of individuals in recovery from mental illness. An aim was to identify the factors, from the perspective of participants, that contribute to unemployment. Additionally, participants' explanations of how these factors lead to continued unemployment were sought. Finally, participants' views of recovery in relation to employment and receipt of SSI was explored.

The following literature review will first provide a definition of serious mental illness and how it impacts an individual's life, including employment. Second, the meaning of recovery and its implications for those with mental illness will be introduced. Third, the benefits of employment, and the high unemployment of individuals with mental illness are discussed. Forth, an overview of SSI will be presented. Fifth, poverty and its perpetuation of unemployment will be examined. Lastly, the influences of the labor market will be presented.

Defining Serious Mental Illness

Serious Mental Illnesses are medical conditions, brain disorders that disrupt a person's thinking, feeling, mood and interpersonal capacity (American Psychiatric Association, 2013; NIMH, 2017). SMI include major depressive disorder, schizophrenia, bipolar disorder and schizoaffective disorder. These illnesses result in functional impairments that substantially interfere with or limit one or more major life activities (SAMHSA, 2012; NIMH, 2017). Major life activities include working, learning, and self-

care (Brennan, 2013). For those with SMI, functional limitations can impact the ability for self-care, independent living and employment.

Difficulty concentrating, diminished stamina, high anxiety and interpersonal difficulties are some of the limiting functions experienced by people with SMI (Boston University Center for Psychiatric Rehabilitation, n.d.; Loy, 2010). Difficulty concentrating can be caused by restlessness, shortened attention span, and the inability to screen out environmental stimuli, such as sounds (Loy & Whetzel, 2015) Diminished stamina may limit a person's ability to work a full day and is often associated with drowsiness due to medication side effects. Multi-tasking, dealing with time pressures and discomfort with change may also be problematic for individuals with SMI. Interpersonal struggles may interfere with social interactions with coworkers and the ability to fit-in.

Serious Mental Illness-Recovery

Defining recovery in regards to SMI continues to evolve. Two definitions of recovery have been distinguished by Davidson & Roe (2007) in their literature review on recovery: recovery *from* SMI and recovery *in* SMI. They posit that between a quarter and two-thirds of individuals diagnosed with SMI will recovery *from* SMI. Davidson and Roe define this as symptoms and other associated deficits are minimized to the extent that they no longer interfere with daily functioning. Recovery in SMI is a newer concept and does not require remission of symptoms or other deficits, but views SMI as only one facet of a person's life (Davidson & Roe, 2007). This concept of recovery refers to a person with SMI reclaiming the right to a safe, dignified, personally meaningful and satisfying life in the community while continuing to have a mental illness. Individuals with SMI are credited with this concept of recovery. Since the 1970's, the consumer survivor

movement has advocated control over one's own decisions in treatment and life choices (Zinman, Budd, & Bluebird, 2009). Consumer survivors are people with mental illness who have rejected the notion that they are patients and have fought on their own behalf to be identified as people first who are much more than their illness. Hence, recovery refers to overcoming the effects of being a mental patient, and the iatrogenic—unintentional yet harmful side effects of treatment—effects of treatment that lead to a loss of a sense of self, identity, valued social roles, and purpose in life, which usually leads to isolation, substandard housing and, unemployment.

Principles of recovery. In 2004, over 110 experts participated in the National Consensus Conference on Mental Health Recovery and Mental Health Systems, coming together for the purpose of defining a working definition of recovery. Mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organizations, federal, state and local public officials were all included. As a result of this collaboration, ten fundamental components or principles of recovery were identified: self-direction, individualized and person centered, empowerment, holistic, non-linear, strength-based, peer support, respect, responsibility, and hope (SAMHSA, 2012). Recovery is not an elimination of symptoms or deficits. It is “.....a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential” (SAMHSA, 2008, p. 1). The mental health system in the U. S. is slowly moving toward a wellness and recovery focus as governmental support of this definition gains strength through legislation and funding.

Contemporary federal legislation has begun to promote a wellness and recovery focus. President George W. Bush's New Freedom Commission on Mental Health (2002) called for significant system to strongly support recovery initiatives. Recovery as cited within Transforming Mental Health Care in America, Federal Action Agenda: First Steps, is identified as the "single most important goal" (U.S. Department of Health & Human Services (2005, Executive Summary) or outcome of mental health services.

Benefits of Employment

Work has been shown to contribute to recovery (Bush, Drake, Xie, McHugo, & Haslett, 2009; Drake & Whitley, 2014; Dunn et al., 2008; Mechanic et al., 2002). Studies indicate that work increases self-esteem, provides a valued identity, lessens symptoms, and improves finances (Dunn et al., 2008; Swarbrick, 2006). Work is also a valued social role that provides healthy interchange among adults. Although recovery is an individual process, for many, recovery is the ability to work, be independent, have friendships and contribute to one's community. Work assists adults in regaining physical, mental and emotional balance in their lives.

For this study, the term employment is used interchangeably with the term *competitive employment*, a legislated term. Vocational Rehabilitation's federal regulation defines competitive employment as work:

in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting...for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled. (Code of Federal Regulations, 2010, 34 CFR 361.5[b][11])

By definition, volunteer, non-paid, under-the-table, stipend and extended or sheltered employment are all excluded.

High Unemployment for Individuals with Serious Mental Illness

Unemployment for individuals with SMI is significantly higher than for other disabilities (Perkins & Rinaldi, 2002; Zwerling, 2002) or for people without disabilities (BLS, 2018; WHO, 2018). Research has found the unemployment rate for individuals with SMI in the U.S. to be as high as 60-90% (NASMHPD, 2007; SAMSHA, 2012). Unemployment of individuals with SMI varies by state. Substance Abuse and Mental Health Services (SAMHSA), an agency within the U.S. Department of Health and Human Services, publishes rankings of unemployment rates of people with SMI in all 50 states. Five states with the highest unemployment rate are, Maine (92.6%), West Virginia (91.9%), Hawaii (91.4%), Pennsylvania (90.6%), and California (90.0%). Five states with the lowest unemployment rate are, Wyoming (56.1%), North Dakota (62.9%), New Hampshire (67.3%), Iowa (68.4%), and Kansas (70.2%). New Jersey ranks 44th with an unemployment rate of 71.1% (SAMSHA, Uniform Reporting, summary, 2012).

Psychiatric Rehabilitation literature addresses several contributing factors to the high unemployment rate of individuals with SMI (Cook, 2006; McAlpine & Warner, 2002), including ongoing symptoms, educational and work deficits, lack of effective services, poverty, labor market, and above all the disincentives built-in to the federal disability system (Cook, 2006; Henry et al., 2016; Johannesen et al., 2009; McAlpine & Warner, 2002). Additionally, perceived barriers, both illness-related and those affecting the broader general workforce (Corbière, Mercier, & Lesage, 2004; Johannesen et al., 2007, 2009), can negatively impact employment for individuals with SMI. If individuals

think they are too ill to work or will be worse-off mentally and financially there is diminished motivation to work. This lack of motivation is irrespective of the accuracy of these perceptions.

Functional limitations that impact employment. Even for those in recovery and are working, illness related impairments can continue to have an impact on an individual's work and require accommodations to improve employment success (Loy & Whetzel, 2015). Not all individuals with SMI live with the same illness-related impairments nor do they experience them to the same degree. There is a broad range of illness-related impediments, including cognitive deficits, concentration, memory, and organization (Barron & Salzer, 2002; Loy & Whetzel, 2015; Rosenheck et al., 2006). Evaluating functional limitations provides the best appraisal of illness-related impairments. An example of functional limitations is an individual who has difficulty screening out environmental stimuli and is distracted by noise, talkative coworkers, and a busy work environment with lots of activity (Boston University Center for Psychiatric Rehabilitation, n.d.; Loy & Whetzel, 2015). Distractibility, short attention span, difficulty with setting priorities, and remembering verbal directions may interfere with the ability to manage assignments and meet deadlines. Ineffective interpersonal skills have been shown to be a leading cause for job termination. The lack of interpersonal skills may present as the inability to handle negative feedback or interact aptly with colleagues or customers. A change in supervisors, work duties or rules may also be unduly stressful (Tsang, Fung, Leung, Li, & Cheung, 2010). Moreover, the cyclical nature of SMI leaves many people vulnerable to periods of hospitalization and missed days from work. For those who also

have physical or cognitive disabilities finding and keeping work is even more challenging (McAlpine & Warner, 2002).

Educational and work deficits. Half of all cases of SMI begin by age 14, and three quarters by the age of 24 (McAlpine & Warner, 2002; NAMI, The numbers count, 2018; NIMH, 2017), disrupting education and early work experiences. Additionally, this is a time when foundational skills needed to be successful at work are developed. These work readiness skills include interpersonal and communication skills, decision making, and time management. The lack of work readiness skills developed in the teens and early twenties combined with low educational attainment and lack of any additional higher-level training are barriers to employment (Barron & Salzer, 2002; Cook, 2006). Thus, individuals with SMI who have not addressed the above-mentioned deficits and wish to enter the labor market qualify for only low paid, entry level positions.

Lack of effective services. To counteract the negative impact of illness on work productivity, both clinical and vocational support services need to be available and utilized (Cook, 2006). Treatment may include psychotropic medication, psychiatric rehabilitation services or a combination of the two. Without treatment, many people are denied the hope for recovery and the ability to sustain employment. Yet, many people with SMI either do not receive treatment or are receiving inadequate treatment. There are a number of reasons for this, including stigma, long wait times to receive services, and the lack of insurance coverage, or insurance coverage that limits types and length of treatment (Cook, 2006; Harvard Health Publications, 2010; Mental Health Association, 2018; President's New Freedom Commission on Mental Health, 2003; Interdepartmental Serious Mental Illness Coordinating Committee, 2017). Pervasive and demoralizing

stigma has the effect of influencing an individual's non-acceptance of SMI and hesitancy to seek treatment. When an individual does choose to seek treatment, there may be long wait times to see a psychiatrist or other health practitioner. This is especially true for individuals with low socioeconomic status who are dependent on the public mental health system. It is not uncommon for someone in a psychiatric crisis to have to wait a month or longer to receive help (Interdepartmental Serious Mental Illness Coordinating Committee, 2017). Minorities and the poor are particularly vulnerable to inadequate treatment.

Managed care, the primary health insurance option in the U.S., was implemented to reduce health care costs. Plans restrict individual choice and the care received. All but three states were operating comprehensive Medicaid managed care programs by 2010, and states expect to increase the use of managed care to serve Medicaid beneficiaries (Gifford, Smith, Snipes, & Paradise, 2011; Kaiser Commission on Medicaid and the Uninsured, 2013). Individuals who receive SSI are also recipients of Medicaid.

Furthermore, federal vocational rehabilitation (VR) services historically have not provided effective vocational services for individuals with a SMI diagnosis (Bromet, 2005; Cook, 2006; Noble, Honberg, Hall, & Flynn, 2001). Expertise in working with individuals with SMI seems to be lacking at local VR offices, and funding standards are set that better serve other disabilities (Noble et al., 2001). The most effective evidence-based employment service is shown to integrate both clinical treatment and vocational services (Bond, 2004).

Impact of poverty. The Federal Department of Health and Human Services' 2018 poverty guidelines for an individual living in one of the 48 border states is \$12,140/year (DHHS, 2018) or \$1,012/month. This is well above the \$750 paid to SSI recipients, even in those states that augment monthly cash benefits. For example, New Jersey pays an additional \$31.25, bringing the monthly amount to \$781.25 (SSA, Security Online, 2018; SSA, SSI Federal Payment Amounts 2018). Fortunately, many recipients are also eligible for additional poverty program assistance such as food stamps and rental subsidies (Institute for Research on Poverty, 2018).

Poverty has a negative impact on individuals with SMI. Adequate medical care, both physical and psychiatric, are often not received by individuals living in poverty (DeNavas-Walt, Proctor, & Smith, 2010; Proctor, Semega, & Kollar, 2016; WHO, 2018). Adequate living conditions and a healthy diet are also wanting (National Coalition for the Homeless, 2009). Individuals with SMI are known to, on average, die 10 to 20 years prematurely (Vreeland, Minsky, Gara, & Toto, 2010; WHO, 2018) owing to the prevalence of metabolic syndromes including diabetes, coronary heart disease, cholesterol abnormalities, obesity, and stroke (NHLBI-NIH, 2011). Poverty contributes to the increase in mortality rate through poor integration of medical and psychiatric care, untreated diabetes and heart conditions, and sedentary life styles.

Work, the one thing that can help people get out of poverty, is often difficult for people living in poverty to get and keep because of the cost of a job search and the resources needed to maintain employment (Cook, 2006). Not having the funds to pay for appropriate interview clothes or transportation to a job interview is common among people with SMI who rely solely on SSI benefits. Once employed, these same issues of

purchasing appropriate work clothing and transportation costs continue. Job requirements like tools and uniforms can also be expensive to purchase even when job skills are present.

Labor market impact. Two labor market issues directly impact individuals with SMI, availability of jobs for individuals with functional impairments and stigma. Global competition for jobs continues to define the 21st century labor market, and jobs for people without advanced education or stable work histories are limited (Amsden, 2010; Stevens, 2018). The diversity and accessibility of jobs once available in the U.S. have diminished, leaving individuals with limited skills with restricted job options.

It is difficult for people with SMI to find employment in a competitive labor market that values fast-pace, multi-tasking, and team orientation (NACE Research, 2007). Review of the literature shows employers are less willing to hire individuals with mental illness than those with physical disabilities (Unger, 2002), and are more concerned with the interpersonal skills of employees with mental, emotional, or communication disabilities compared to individuals with physical disabilities (Hand & Tryssenaar, 2006; Rimmerman, 2007). Communication skills, working and relating well with co-workers, taking initiative, and having a strong work ethic are the top five skills employers look for in job candidates (NACE Research, 2007).

An unfavorable labor market negatively affects many working age adults but seems to have a larger impact on individuals with SMI (Cook, 2006). The additional stigma and discrimination make people with SMI more vulnerable to job termination. Employer surveys show higher negative attitudes towards hiring and promoting workers with SMI than any other disability group (Dalgin & Bellini, 2008; Diska & Rogers,

1996). Perkins and Rinaldi's (2002) study, spanning ten years, examined the vocational status of individuals with SMI in England. They found that unemployment for people with long term mental health problems increased steadily despite a decreasing rate of unemployment for the general population (Perkins & Rinaldi, 2002).

Legislation. The landmark passage of the Americans with Disabilities Act (ADA) of 1990 has not fully achieved workforce equality for individuals with disabilities. Discrimination continues to be common, particularly for individuals with SMI (Unger, 2002). The impact of the final 2011 regulations of the *Americans with Disabilities Act Amendments Act* (ADAAA) of 2008 remains unseen (ADAAA, Federal Register, 2011).

Supplemental Security Income

Supplemental Security Income (SSI) is a disability benefits program funded by the U. S. general tax revenue. Title XVI of the Social Security Act authorizes SSI benefits (SSA Red Book, 2017). SSI provides financial benefits to the aged or disabled based on monetary need and limited or no work history. SSI provides cash to meet basic necessities such as food, clothing, and shelter (SSA Red Book, overview, 2017; SSA Red Book, general info, 2017; SSA Online, SSI home page, 2018). Many states with high cost of living additionally augment the Federal benefit amount, for example, New Jersey pays an additional \$31.25 bringing the monthly amount to \$781.25 (SSA/SSI, 2017).

Eligibility for SSI. To receive SSI benefits, a person must meet specified eligibility requirements. These requirements include limited or no income, limited work history, and assets under \$2,000.00. Additionally, a person's disability must be expected to last longer than a year or will end in death and be severe enough to interfere with the ability to work at a substantial gainful activity (SGA). SGA as defined by SSA is a

monthly dollar amount and indicator of a person's ability to work (SSA Red Book, 2017). It is not a measure of adequate income. In 1957, when SGA was first established, the amount was \$100 a month. SGA has increased periodically; \$300 in 1980 and \$500 per month in 1990. In January 2018, the SGA level was set at \$1,180 (SSA, Social Security Online, 2018). Thus, a person making \$1,180 or more gross income in any one month would not be eligible for SSI irrelevant of the severity of his disability.

Social Security work incentives. Work incentives are part of SSA legislation intended to help beneficiaries go to work by minimizing the risk of losing their SSI or health (Medicaid) benefits (SSA Red Book, 2017). Work incentives were introduced to the SSI program in 1980 and have been improved upon since. The most recent legislation improving work incentives for SSI recipients is the Ticket to Work and Work Incentives Improvement Act (TWIAA) of 1999 (Public Law 106-170) (Policy Options, 2003).

There are several work incentives under The Ticket to Work Legislation; the most significant work incentive relevant to this study is the earned income exclusion. Under the earned income exclusion, gross income up to \$85 in a month is not counted against a beneficiary's SSI benefits. Any income earned above \$85 reduces an individual's SSI check by one dollar for every two dollars earned. In other words, one-half of the amount of a person's earned income above \$85 is deducted from the person's SSI benefit amount. This calculation is based on gross earned income and is calculated each month.

Individuals who have sporadic work or varied work hours need to have the SSI benefit amount re-calculated every month in which they earn income (Halloran, 1991). The Social Security system is not efficient, delays in recalculation often leave SSI recipients with benefit shortfalls or overpayments that they must pay back. Working may also result

in a loss or reduction in housing subsidies, food stamp allowance, and in some states medical coverage, further complicating the decision to return to work (GOA, 1999; Halloran, 1991; McDonald-Wilson et al., 2003).

Conclusion

Millions of people in the U.S. have a diagnosis of a SMI. Many suffer for years until they find medications, coping mechanisms, and supports that help them live productive lives. Growth of the recovery concept and psychiatric rehabilitation have provided more effective treatments and services making recovery and wellness a reality for many people living with SMI. But a paradox presents itself, although recovery is now an accepted outcome for individuals with SMI and employment is recognized as contributing to recovery, many individuals with SMI remain unemployed.

Various reasons for this unemployment have been gleaned from existing literature and are seen to have direct significance to this study. In the present economy and changing U.S. labor market jobs paying a living-wage are not available for individuals trying to re-enter the workforce. Some individuals in recovery from SMI may still experience symptoms and functional limitations that make gaining and keeping employment difficult. Re-entering the workforce is further exacerbated by limited work history and insufficient educational level. What ensues is dependency on SSI and a life of poverty.

A question that remains, how do individuals experiencing recovery from SMI and life on SSI explain enduring unemployment? A grounded theory approach will be used to address the issue of continued unemployment of people in recovery from SMI and are receiving SSI. Poverty and the disincentive of receiving SSI benefits is of interest in this

study. A life of poverty is a reality for too many people with SMI living on SSI and can only be truly understood by those who are living this experience.

Chapter 3

Methods

Although recovery is becoming an increasing reality for individuals with SMI (Davidson & Roe, 2007; Dunn et al., 2008; Spaniol, Wewiorski, Dunn, & Chamberlin, 2005), many do not attain competitive employment (Baron & Salzer, 2002; Bureau of Labor Statistics [BLS], 2017; BLS, 2018; Mueser et al., 2001; NAMI, 2014a). Instead, they continue to receive long-term disability benefits and live in poverty (Amsden, 2010; Coulton, 1996; Danziger et al., 2009; Marrone & Golowka, 1999). Much research has been conducted exploring the multiple reasons for unemployment for individuals with SMI. What has not been addressed is the high unemployment of individuals with SMI who state that they are in recovery. The purpose of this qualitative study is to gain an in-depth understanding of the factors that influence employment status from the perspective of individuals who identify as “in recovery” from SMI. A substantive theory will be developed utilizing grounded theory methods.

The overarching research question is: What is the process that leads to ongoing unemployment of individuals in recovery from SMI? Research questions were crafted to develop theory substantiating the process of enduring unemployment of individuals in recovery from SMI.

1. What is the process that leads to continued unemployment of individuals in recovery from SMI?
2. What factors identified by individuals in recovery from mental illness contribute to their unemployment?

3. How does paid employment fit into the definition of recovery for individuals in recovery from SMI?
4. How do individuals in recovery from SMI make the decision to work, or remain unemployed?
5. From the perspective of individuals in recovery from SMI, what needs to happen for them to choose employment?

Assumptions of and Rationale for Qualitative Inquiry

Qualitative research is the most appropriate approach to gain understanding and meaning—consequences, significance, implications—from the perspectives of study participants (key informants). Qualitative research accepts that there are different ways of making sense of the world in which we live. It allows study participants to expound their views, experiences, beliefs, and motivations (Gill, Stewart, Treasure & Chadwick, 2008), enabling a deeper and broader understanding and interconnectedness (Becker, 2009; Jones & Rogers, 1995; Miles & Huberman, 1994) of the process that leads to sustained unemployment. Continued unemployment of individuals in recovery from SMI, who are receiving SSI, has not been addressed in the literature; therefore, qualitative research is an appropriate design to explore this phenomenon.

The following characteristics of qualitative studies, as defined by Creswell (2007, 2013) were incorporated into this present study design. Interviews were conducted at mental health programs in the community where participants' received treatment or support. Data was gathered from multiple participants allowing for a deep understanding of the problem. As the researcher I was a key instrument in the data collection, personally gathering all data. This research is interpretive, based on what I saw, heard, and

understood. Interpretations could not be totally separated from my history and understanding. A constructivist worldview is evident throughout this study, along with a holistic approach, which included multiple perspectives and complex interactions. Data analysis is inductive with a focus on meanings developed from the perspective of the study participants.

Grounded Theory as a Strategy of Inquiry

Historically, grounded theory has taken divergent paths since its inception in the 1960's (Charmaz, 2006, 2009, 2014). As a researcher, I chose to employ grounded theory methods and procedures as defined by Charmaz (2006, 2009, 2014). Charmaz takes a constructivist stance and views grounded theory as emerging through interaction. The conceptual framework or lens for this study is strongly supported by Charmaz's indications of grounded theory. Grounded theory research is interactive, fluid, and open-ended. As a researcher I was part of this study, interacting with participants and the data. Ambiguity was dealt with throughout the data collection and analysis. Additionally, research questions informed initial methodological choices for data collection. Analytic direction arose from my interactions and interpretive comparisons of emergent concepts. Ongoing analysis of the data shaped the conceptual content and direction of my study.

Theory development. I employed a grounded theory approach for the purpose of developing theory that explains the relationship of various factors and the process that leads to sustained unemployment of individuals in recovery from SMI. The uniqueness of grounded theory is that it allowed me to go beyond the descriptive nature of other qualitative research methods and develop theory that was grounded in the data (Birks & Mills, 2011; Oktay, 2012; Strauss & Corbin, 1994). By utilizing a grounded theory

method, I was able to explain relationships of events or factors identified by study participants, which lead to continued unemployment of individuals in recovery from SMI. Additionally, I was able to interpret actions taken by the study participants over time (Charmaz, 2006, 2014). Theory, developed from a constructivist stance, emphasizes understanding of the phenomenon of enduring unemployment of individuals in recovery from SMI who receive SSI. This understanding developed through abstraction and is interpretative. Abstraction was reached through inductive reasoning; thus, theory emerges as patterns were identified and concepts formed.

Prior to any recruitment and data collection Rowan's Institutional Review Board's (IRB) approval was obtained. Preliminary to this IRB approval I completed the mandatory *Collaborative Institutional Training Initiative* (CITI) Human Subjects, gained approval from my dissertation committee, and submitted the completed application to the IRB committee.

Sampling

Individuals were purposefully sampled to meet the criteria of the study, which included a lived experience of SMI, self-identification of being in recovery from SMI, and between the ages of 25 and 54. As theory began to develop from the data, participants were theoretically sampled. Theoretical sampling is unique to grounded theory research (Birks & Mills, 2011). Birks and Mills define theoretical sampling as “a process of identifying and pursuing clues that arise” (p. 69) during ongoing data collection, coding and analysis. As data continued to be collected and theory began to develop, I made decisions about the type of data needed to continue theory development. Intake of study participants continued till saturation of categories was achieved, allowing

for sufficient, relevant, and in-depth data. Saturation is defined as the point when gathering fresh data no longer elicits new theoretical insights or reveals new categorical properties (Charmaz, 2006).

Sampling criteria. Study participants met the four following criteria to be eligible for this study. 1.) They have a diagnosis of SMI (major depression, schizophrenia, bi-polar or shizo-affective disorder). Study participants self-identified as having SMI. Medical records were not solicited to confirm diagnosis. 2.) Eligible study participants considered themselves in recovery. Participants lived one year or longer with no psychiatric hospitalizations and resided at least one year in the community. It should be noted that the criteria of recovery to include one year of community integration without a hospitalization was a criterion for inclusion in this study and does not imply that someone not meeting this criterion was not in recovery. 3.) Study participants were between the ages of 25 and 54. This age limit was selected because it is inclusive of working age of adults. Although working adults may fall outside this limit, individuals still in post-secondary education or approaching retirement could confound the study. Additionally, this age delineation is used by the Bureau of Labor Statistics in their reporting. Finally, 4.) Study participants were receiving SSI benefits.

Context. I established contact with three mental health agencies that provide a variety of public mental health programs and services in two northeastern states. These organizations were chosen because of their active connections to a large number of individuals who met participant criteria (Mack, Woodsong, MacQueen, Guest, & Namey, 2005). I had working relationships with two of these agencies. The third agency was referred by a colleague who provided a name and contact information of a high-level

administrator. This agency is well established and has its own IRB process. I presented a written proposal then met with the IRB board who approved my access into their programs. Once permission was given by the appropriate leadership from all three agencies I was able to enter the sites, build relationships with other staff, present the study to groups of staff and potential participants and initiate recruitment.

Recruitment Protocol

An established recruitment protocol was developed. Agency staff were provided with a Request to be Contacted Form to gain written permission from potential participants to be contacted by me (see Appendix A). The Request to be Contacted Form included potential participants' name, contact information, and signature. By providing this information and signing the form, potential participants gave their permission to be contacted by me (HHS.gov, 45 CFR 164.508). This process allowed for the protection of individuals under the Health Insurance Portability and Accountability Act (HIPAA). The mental health organizations where participants were recruited are bound by HIPAA legislation and needed individual permission from potential study participants to provide individuals' names and telephone numbers because these are considered Protected Health Information. Although agencies did have potential participants complete the Request to be Contacted Form telephone contact to set up meeting time and location was never needed. The agencies, where participants were recruited, coordinated the meeting location and time and provided me office space to meet with potential participants. All contact and meetings took place exclusively at the mental health agency where the participants attended.

Additionally, an advertising flyer was posted at study sites to advertise the study (see Appendix B). Individuals could then refer themselves by contacting me directly. No potential participants contacted me independently.

Data Collection

Data collection took place in the field, at the sites where participants attended mental health programs. Demographics, Participant Recovery Scale, in-depth semi-structured interviews, and memos were utilized following established IRB protocol. Prior to data collection informed consent was completed.

Informed consent protocol. At the initial meeting, an informed consent (see Appendix C) was reviewed with the potential participant and any questions about the study were answered. Participant signatures were secured on the informed consent prior to starting the interview. If a potential participant met the study criteria and agreed to enter the study, data collection began. This consent additionally includes consent to be tape recorded.

Demographic protocol. Data collection began with a one-page, Demographic Intake Questionnaire (see Appendix D). At this time, I assigned a participant ID number that was used on all data collection forms to protect the confidentiality of study participants. I asked each participant for the information on the demographics form and personally filled them out for each study participant. In this way I was able to continue developing rapport, assure that all information was given, and to probe for answers when the participant was unsure of accuracy. As this study met with each participant only once the ID number had no link to individual participants, further protecting individual identity.

Recovery scale protocol. A Participant Recovery Rating Scale (PRS) (see Appendix E) was developed to gather subjective data about personal recovery from study participants. The first three study participants were given the PRS, directions reviewed and clarified. Participants were given time to independently complete the scale. This scale was not used past the first three participants as more in-depth information about recovery was gained from interview questions. The PRS was developed specifically for this study and may be too vague to solicit useful information about an individual's recovery.

Interview protocol. Semi-structured interviews began with an explanation of the expectations for the interview. Study participants were asked several questions about experiences with SMI, recovery, and employment. Participants were informed that there were no right or wrong answers and their responses will contribute to the study and understanding of their experiences. All participants gave permission during the informed consent interviews to be digitally recorded. I additionally took hand written notes as a backup to recording failure. Written notes were additionally used to document information and nuances that were not identifiable orally, e.g. non-verbal communication. The study participants were informed that they could review the hand-written notes.

Interviews began following the Interview Questionnaire (Appendix F). Follow-up and probing questions were used to elicit elaboration of participant's knowledge, views, and experience and produced deep and rich descriptive data (Charmaz, 2006, 2014; Mack et al., 2005; Merriam, 2009). Interviews ended once all interview questions were explored fully. Participants were thanked for their participation and asked if they had any further questions before ending their participation in the study.

Memo writing protocol. Lempert (2007) describes memoing as “asking questions of the data” (p. 245). It became part of the data analysis and directed additional data collection. Memo writing was essential to this grounded theory study, it advanced engagement, analysis, and interpretation of the data (Bryant & Charmaz, 2007; Charmaz, 2006, 2014). Memos allowed for the time and thought to identify emergent patterns and to develop increasingly abstract ideas and concepts, leading to theory development.

Instrumentation. Two instruments were used to gather data for all study participants. Discussed below are the Demographics Intake Questionnaire and the Interview Questionnaire.

Demographics. The Demographic Intake Questionnaire collected the following information: ethnicity, age, gender, diagnosis, brief employment history, and additional entitlement incentives of participants (Appendix D). This data was used to provide contextual demographics of interviewees in total.

Interview Questionnaire. The primary method of data collection used in this study was the semi-structured Interview Questionnaire. Interview questions were developed to guide the interview (Appendix F). This guide assured that all relevant questions to the study phenomena were covered and comparable data collected (Cohen & Crabtree, 2006). Flexibility of the semi-structured interview, along with the use of open ended questions allowed the study participants to use their own words, diverge from the interview guide, and identify new ways of seeing and understanding the study phenomena (Stuckey, 2013). Examples of probing questions are included in the interview protocol, and additionally helped in gathering data that revealed in-depth data.

Sixteen interview questions explored study participants views of: recovery, employment, the relationship between recovery and employment, their employment decision making process, and suggested changes in the mental health and Social Security system that would benefit their pursuit of employment. Table I identifies the initial interview questions developed to answer the research questions.

Table 1

Research Questions in Relation to Interview Questions

Research Questions	Interview Questions
1. What is the process that leads to continued unemployment of individuals in recovery from mental illness?	4, 6, 8, 11, 13, 14, 15, 16
2. What factors identified by individuals in recovery from mental illness contribute to continued unemployment?	3, 4, 5, 6, 9, 10, 11, 12, 14, 15, 16
3. How does paid employment fit into the definition of recovery for individuals in recovery from mental illness?	1, 2
4. How do individuals in recovery from mental illness make the decision to work or remain unemployed?	4, 6, 8
5. What needs to happen for individuals in recovery from mental illness to choose employment?	7, 9, 12, 13, 14, 15, 16

Note. Adapted from “Qualitative Analysis on Stage: Making the Research Process More Public,” by V. A. Anfara Jr., K. M. Brown, & T. L. Mangione, 2002, *Educational Researcher*, 31(2), p. 32. Copyright 2002 by the American Educational Research Association; reproduced with permission of the publisher.

All study instruments, along with the time spent in the field, were designed to gather enough data to develop analytic categories, make comparisons between data, and use these comparisons to generate and inform ideas, and theory.

Data Analysis

Grounded theory studies are fluid (Charmaz, 2006). Data analysis began with the first interview. Ongoing analysis of the data shaped the direction of the study. As data was collected from one participant and analyzed, it was then used to compare to subsequent data. As new concepts and understanding arose, interview questions were revised to assure continued exploration of emerging themes.

Data analysis for the current study commenced by preparing the data. All interviews were transcribed within two weeks of each interview. Coding began as soon as each transcription was completed. This method of coding as you go is consistent with grounded theory methodology (Charmaz, 2005, 2006, 2008, 2009, 2014; Creswell, 2007, 2013).

Coding. Three kinds of coding were used in this study, open, focused, and theoretical (Charmaz, 2006, 2014; Creswell, 2007, 2013). This is consistent with a constructivist approach to grounded theory. Constructivist inquiry looks at how people construct realities of the experience in which they participate. Constructivist researchers enter a phenomenon and gain multiple views of it, including connections and constraints. Constructivist researchers acknowledge that their interpretation of a studied phenomenon is itself a construction (Bryant & Charmaz, 2007).

The initial coding phase—open coding—began analysis by fragmenting data, words, lines, and segments (Charmaz, 2006, 2014). Line-by-line open coding accounted for each piece of data. Large quantities of codes were generated; open coding was the first step in making analytic interpretations of the data. Once this phase was completed, focused coding began. By using a constant comparative approach, codes were eliminated

that did not hold up under comparison. Data reduction took place as coding and recoding moved raw data from large, unwieldy segments into categories, subcategories, and themes (see Figure 1).

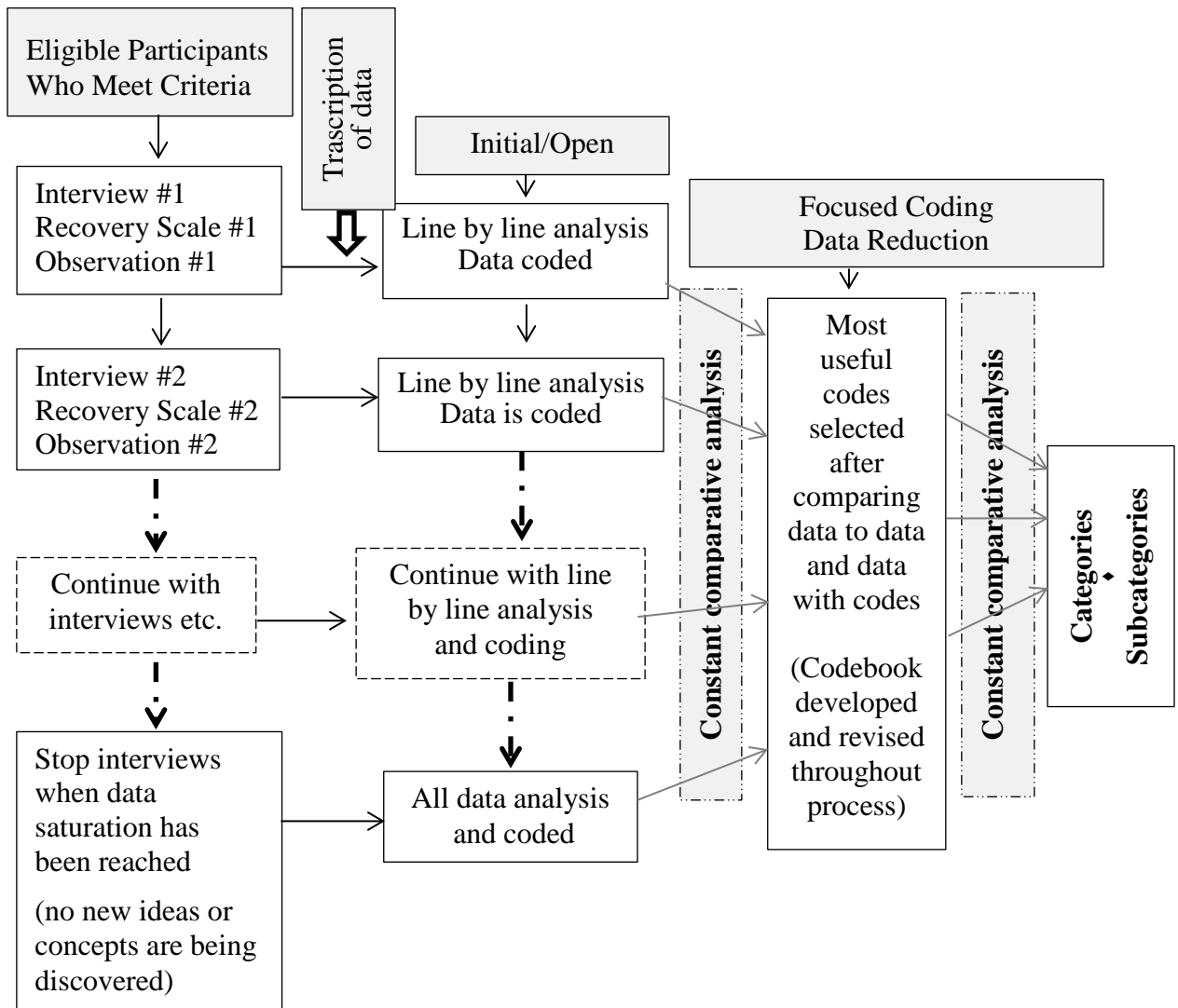


Figure 1. Data Collection and Analysis, Initial and Focused Coding

Strauss and Corbin's (1998) structured strategy of developing grounded theory was not selected for this study. Charmaz's constructivist grounded theory approach

provided more flexibility to allow categories and themes to emerge unrestricted by a preset structure potentially limiting the analysis (Charmaz, 2006, 2014).

The second phase, focused coding, brought the numerous codes identified during the initial coding phase together (Charmaz, 2006, 2014). Focused codes were developed as initial codes begin to show patterns and relationships identified by the constant comparison of data to data and data to codes.

Finally, theoretical coding began to specify possible relationships between categories (Charmaz, 2006). Theoretical codes aid in making analysis of data coherent and are developed through theoretical sensitivity. Birks and Mills (2011) state theoretical sensitivity is instrumental to developing grounded theory that is deep, rich and credible. It is the ability to recognize and extract from the data elements that are meaningful and relevant to theoretical constructs and emerging theory (see Figure 2).

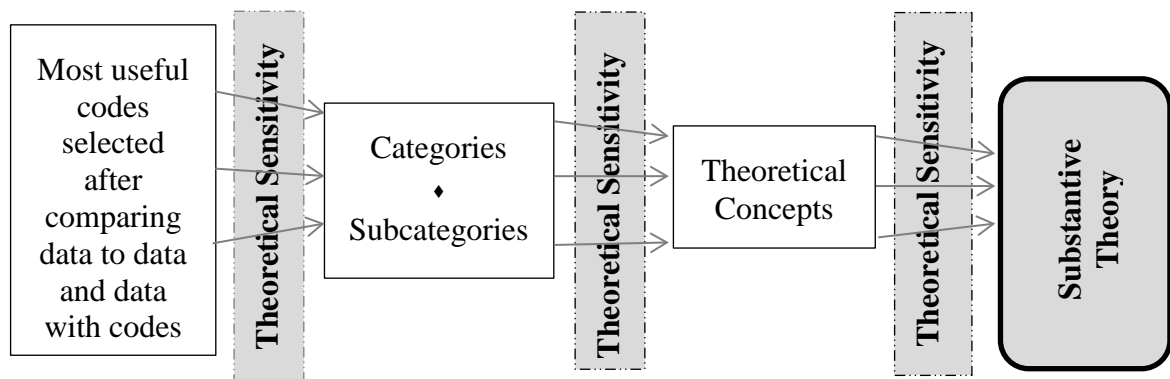


Figure 2. Theoretical Coding and Analysis

Theoretical sensitivity was developed by spending much time with the study data and thinking about new ways to understand its meanings (Charmaz, 2006, 2014). The

theoretical concepts, and ultimate substantive theory, will grow out of seeing possibilities from various vantage points, by making comparisons, by establishing connections, by asking questions, and following leads (Charmaz, 2006, 2014). In this way theories arise out of the data. Writing memos throughout the coding process assisted in documenting, expanding, and making final decisions about the developing theory.

By using this coding and analytic process, a substantive theory on the employment decision-making process and enduring unemployment of individuals in recovery from SMI was developed. This theory helps explain the interconnectedness and complexity of a decision-making process that is impacted by factors most relevant and understood by individuals living with SMI.

Charmaz (2006, 2014) emphasizes focusing on actions and process rather than descriptive coding. Exploring the process or phases of employment decision-making will fosters efforts to construct theory by defining and conceptualizing relationships between experiences, events, and decisions. Considerable analytic work within and beyond coding and category construction assured that findings made empirical and theoretical sense (Charmaz, 2006, 2014).

Data interpretation. Interpretation of data is interwoven into the core characteristics of grounded theory research (Charmaz, 2006, 2014). Analytic interpretation begins with the first code, and strengthens through time spent with the data, and theoretical sensitivity. Iterations of this data analysis will be displayed in table format (see Table II). Additionally, data in the form of participant quotes will be used in the study's findings to support interpretations and allow the reader to understand the interpretive stance. As categories and themes emerge from participant statements

throughout the coding process, diagramming and mapping were used to display interpretations.

Developed theory is presented in chapter four through detailed writing of my theoretical interpretation. This theoretical framework (Charmaz, 2006, 2014) expounds the theory's direction, its logic, position it in relation to prior theoretical works, and explains the significance of original concepts. Additionally, a grounded theory model is displayed and accompanied by narrative that explains its key components (Birks & Mills, 2011). A grounded theory model is differentiated from a diagram in that a diagram is a strategy for analysis, while a model is a presentation of component parts of a grounded theory. The grounded theory model presented in this document is a summative visual representation of the study findings with a focus on abstraction, logic and flow.

Rigor of Study Design

Rigor was addressed by following standards of rigor for qualitative studies. Criteria for evaluating qualitative research are denoted as credibility, transferability, dependability, and confirmability (Anfara, Brown & Mangion, 2002; Toma, 2005). Credibility can be explained as the accurate account of findings in the eyes of those being studied (Toma, 2005). In other words, the findings and theory developed in this study accurately portray the lived experience of study participants. This standard may also be described as internal validity. It was realized by spending maximum time in the field (Anfara et al., 2002; Creswell, 2007, 2013; Toma, 2005). Maximum time means giving participants time to fully tell their stories and perspectives. Participants were interviewed until saturation was achieved. Transferability is the ability of qualitative findings to illuminate other settings than the specific context studied (Toma, 2005). Transferability

was achieved via purposeful sampling and thick, rich descriptions of both the data and themes developed from the data. Dependability is defined as an accurate reporting of research and its findings over time (Toma, 2005). Inherent in qualitative research is the evolution of the study over time. Any changes or departures from the original design must be fully disclosed so others have detailed insight into all phases of the study.

Dependability was accomplished by creating an audit trail, keeping adequate and detailed field notes and writing memos throughout the entire coding and analysis phases. Code mapping strategies were implemented as presented by Anfara et al. (2002). Ongoing iterations of analysis allows the reader to follow the researchers analytic process. Anfara et al. assert validity in qualitative research includes the public disclosure of the coding and theme development process (see Table II).

Confirmability is the concept that data findings can be confirmed by others and is not the bias of the researcher (Toma, 2005). It was addressed by utilizing triangulation in the form of multiple participant data and utilization of three coding examiners. Because personal history and views may influence coding and analysis a section below titled reflexivity, along with a section titled researcher assumptions and biases, in chapter five are presented. Setting aside preconceived ideas about the phenomenon being studied was ongoing, allowing codes and themes to emerge from the data, unencumbered by past research or knowledge. Three independent researches were employed as code examiners to increase accurate and relevant coding. All three researchers have conducted qualitative research and are experienced in qualitative data coding. Any coding discrepancies were resolved by discussion and consensus among coders and researcher.

Table 2

Code Mapping: Three Iterations of Analysis (to be read from the bottom up)

Code Mapping Mental Illness, Recovery, and Employment				
Research Questions 1, 2, 3, 4 & 5				
RQ1	RQ2	RQ3	RQ4	RQ5
Overriding Themes				
<i>(Themes derived from the three iterations are formed here)</i>				
Third Iteration: Application to Data Set				
Answering RQ1	Answering RQ2	Answering RQ3	Answering RQ4	Answering RQ4
Second Iteration: Pattern Variables				
1a, Finding Categories 1b 1c, d, etc.	2a. 2b, c, d	3a, b 3c, d 3e	4a 4b 4 c, d	5a 5b 5c
First Iteration: Initial Codes/Surface Content Analysis				
1a In-vivo coding 1b 1c, etc.	2a 2b 2c 2d	3a 3b 3c 3d	4a 4b 4c 4d	5a 5b 5c 5d
DATA	DATA	DATA	DATA	DATA

Note: adapted from “Qualitative Analysis on Stage: Making the Research Process More Public,” by V. A. Anfara Jr., K. M. Brown, & T. L. Mangione, 2002, *Educational Researcher*, 31(2), p. 32. Copyright 2002 by the American Educational Research Association; reproduced with permission of the publisher.

Grounded theory studies include additional criteria for evaluating the generated theory: originality, resonance, and usefulness (Charmaz, 2006, 2014). Originality strives for fresh categories and new insights. This study provided new concepts and

interpretations of the data, extending and refining the current view surrounding the enduring unemployment of individuals in recovery from SMI who receive SSI benefits. Subtle meanings were explored, challenging taken-for-granted meanings. The emergent grounded theory offers deeper insights about the lived experience of study participants. Maintaining an *audit trail* was a key strategy in promoting quality grounded theory methods (Birks & Mills, 2011). An audit trail was developed with a written record of decisions made during all stages of this research.

Reflexivity

Reflexivity is defined as an active, disciplined process used by a researcher in order to gain self-insight and increase objectivity, and to guide actions and interpretations within a research study (Birks & Mills, 2011). I have worked in the field of psychiatric rehabilitation for 18 years and have familiarity with its policies, literature and stakeholders—individuals with mental illness, clinicians, family members, state overseers and policy advocates. This closeness to the research topic was beneficial. Although this familiarity could have potentially distorted perceptions of the data (McGhee, Marland & Atkinson, 2007). Strategies were undertaken to prevent preconceived ideas from swaying research outcomes and grounded theory development. Bracketing, or using reflexivity assisted in maintaining objectivity (Birks & Mills, 2001). The reflexive strategy of journaling to identify thoughts, feelings and perceptions was used. Additionally, this journal of memos maintained an audit trail of decisions and procedures undertaken during the study (Birks & Mills, 2011).

The Role of the Researcher

Qualitative research sees the researcher as the key instrument in the research design (Creswell, 2007, 2013). As the researcher I brought my worldview and assumptions into the development of the research questions and study protocol. Even with use of reflexivity, all research segments—interview, coding, data analysis, theory development, and presentation passed through my filter. Identified as a constructivist, I saw myself as a subjective and active participant in data generation and collection. Unlike first generation grounded theorists (Glasser, 1978; Glasser & Strauss, 1967; Strauss & Corbin, 1990), second generation grounded theorists (Birks & Mills, 2011; Charmaz, 2006, 2009, 2014) posit it is impossible to separate the researcher from participation in the generation of data. There was reciprocity between me as the researcher and the participants. Data was perceived as being generated not just collected. Knowledge was constructed from the interactive relationship between the researcher and participant, thus generating data.

A constructivist paradigm underpins this study. Constructivists believe that individuals create knowledge and meaning from the interaction between their experiences and their internalized beliefs about the world (Charmaz, 2005, 2006, 2008, 2009, 2014). Individuals with SMI have a history of influential experiences prior to recovery—work history, impact of their mental illness and life on SSI benefits. Recovery, which allows for regaining control of one's life, has its own significance for each person and adds to the construction of meaning. Prior experiences, beliefs, values, sociocultural histories, and perceptions all influence decision making. Simultaneously, outside forces also had an impact on employment related decisions. These outside forces include Social Security

legislation, associated entitlement programs, and labor force influences. This study increased understanding of the study phenomenon and developed theory (Creswell, 2007, 2013) explaining the factors and process that influence employment decision making.

Researcher biases. As the primary and sole researcher, I am aware of several biases that had the potential to influence data collection, coding, and analysis. My personal biases include a strong belief in the benefits of paid work for individuals with mental illness in any phase of recovery. In fact, I see employment as a tool in achieving recovery. I do realize this may not be the same perceived belief garnered from study participants. I additionally have a strong belief that poverty has more disabling qualities than may be evident from the symptoms of mental illness. I am also aware that my definition of poverty, quality of life, and the necessities of life, may differ from those I will be interviewing.

Even though I have worked in the mental health field for 18 years, I identified as an outsider in regards to the phenomenon being studied. I am middle class, have worked continuously for more than 30 years, and do not have a diagnosis of a major mental illness. This is in direct opposition to the criteria being used in this study to select study participants. My years of experience working with individuals with mental illness—most unemployed and living in poverty—has honed my skills in developing rapport through showing respect and a humble attitude. This contributes to increasing comfort and openness in discussing sensitive subjects.

Ethical Considerations

Awareness of potential ethical issues prior to and throughout this research study was vital to prevent scholarly or legal complications. Protection of study participants,

maintaining rigor in the study design and methods, and the impact of researcher bias are all areas that could possibly have led to ethical problems.

Ethics include being transparent, honest, and respectful with study participants (Saldaña, 2009). Full disclosure of the study procedure and purpose took place during the consent process and throughout the entirety of the study. Additionally, ethics includes rigor in data coding, analysis, and reporting. An example of unethical treatment of data is ignoring or not including data that is divergent from emergent theory. Continually maintaining scholarly integrity in the literature search, data collection, analysis, theory development, and reporting are all vital to conducting ethical research. Rigor in all stages of research, demonstrates respect for study participants by accurately representing their lived experience.

Protection of participants. Studying individuals diagnosed with SMI may be interpreted by many as sensitive in nature. They are seen as a protected category of people by research boards and legislation (ED.gov, 2010). Precautions to protect the rights of individuals with mental illness will be incorporated into the research protocol. Because all participants in this study will be in recovery from mental illness, I am confident that they will have the capacity to act on their own behalf and make an informed decision to enter the study. I am confident in my ability to assess someone's inability to consent and continue the study because of my years of experience in working with individuals with SMI. If any mental health problems are assessed at any time during the study, informed consent or interview will be terminated.

Individuals with mental illness. According to The U.S. government's Health and Human Services (HHS) IRB Guidebook (1993), a predominant ethical concern in research involving individuals with psychiatric disabilities is that their disorder may compromise their judgment and reasoning, thus limiting their capacity to understand information and to give informed consent. The Guidebook additionally advises against overprotection of vulnerable populations, excluding them from participating in research in which they wish to participate. Guidelines supporting inclusion of vulnerable population in research advises that the research pertains to the protected population, research questions focus on an issue unique to individuals in this population, and the research involves minimal risk. The present study—sustained unemployment of individuals in recovery from SMI—upholds all of these matters. Additionally, it is advised that someone knowledgeable about and experienced with working with the vulnerable population is involved in the research. Almost 20 years working with individuals with SMI qualifies me as knowledgeable and experienced.

All study participants for this present research will be in recovery, a criterion for participation in the study, and living independently in their community. Because of their recovery status, concern over their ability to give informed consent is minimal.

Sensitivity of the subject matter. Discussing continued unemployment may be uncomfortable for some study participants, particularly if some events leading to this phenomenon were emotionally painful, e.g., diagnosis of a mental illness or being repeatedly fired from jobs. What I have noted from my years of experience working among individuals with SMI is a culture established within the mental health system that is accepting of unemployment. This acceptance within mental health agencies and among

those who attend may lessen the perceived sensitivity around sustained unemployment. This is speculative; in the future I hope to study the systemic culture of the mental health community in the U.S. to explore my unscholarly assessment.

Power issues. As an ethical researcher I remained aware of power issues that are inherent in doing qualitative research. Kvale and Brinkmann (2009) discuss several of these issues. As a researcher I was the one who is initiating the conversation (interview), setting time limits, setting the topic, and asking the questions while providing limited self-disclosure. I also had the control over deciding what data was important and what was ancillary, and over interpretation of studying findings. Additionally, my role as a highly educated researcher with a professional job may be interpreted by participants as power asymmetry. These issues are not necessarily all negative but remaining aware of the impact this asymmetry on interviews and data collection was kept in the forefront while conducting this study.

Conclusion

Understanding the high under/unemployment of individuals in recovery from SMI can only be truly understood by hearing from the very individuals that are living this experience. Employment is a vitally important issue impacting the life of all of these individuals and society as a whole. Individuals who are unemployed and receiving government benefits are living in poverty. The United States is neglecting a segment of the population who are potentially well enough to be employed and contribute to the tax base. Qualitative research is the best approach to explore and gain a rich understanding of the issues and factors that contribute to this phenomenon. The rigor of a well-designed grounded theory study will contribute to the field of mental health and offer a preliminary

step in making changes that will allow for an increased employment rate of individuals with mental illness.

Chapter 4

Findings

The purpose of this chapter is to present study findings, and substantive theory developed from these findings. Discoveries grew from the analysis of study participants' answers to interview questions. Perceptions, beliefs, and lived experiences as identified by participants lead to an in-depth understanding and answer to the overarching research question, "What leads to the enduring unemployment of individuals in recovery from mental illness who are receiving SSI?"

The chapter is organized in the following manner, it begins with a review of the additional research questions used to guide this study. Second, participant profiles are presented. Next, the procedures or processes of data collection and analysis are provided. Finally, theoretical themes that emerged to develop a grounded theory of the enduring unemployment of individuals with SMI receiving SSI is presented.

The following research questions were used to guide the development of interview questions and to garner an in-depth understanding of the overarching research question: What leads to the enduring unemployment of individuals in recovery from mental illness who are receiving SSI? The data gathered and analyzed supports the findings discussed in this chapter.

1. What is the process that leads to continued unemployment of individuals in recovery from mental illness?
2. What factors identified by individuals in recovery from mental illness contribute to their unemployment?

3. How does paid employment fit into the definition of recovery for individuals in recovery from mental illness?
4. How do individuals in recovery from mental illness make the decision to work, or remain unemployed?
5. From the perspective of individuals in recovery from mental illness, what needs to happen for them to choose employment?

Profile of Participants

Potential participants were recruited from community agencies where they received mental health services and the study interviews took place. All 20 completed the informed consent and demographic questionnaire. Upon completion of the demographics, it became evident that five of the individuals were not eligible for the study. By using probing questions these five participants were able to clarify that they were receiving SSDI, either additionally or in total, instead of only SSI benefits. All five participants were informed of their ineligibility for the study. Individuals receiving only SSI were qualified candidates for this research study. The final sample size was 15.

It is striking that ethnicity among participants is not diverse. This was not intentional and not identified until demographics were analyzed. Twelve of the 15 participants identified as African American, one identified as both Hispanic and African American, one as Native American and one individual identified as other (see Table 3). This study did not include anyone from Caucasian or Asian descent. Ten participants were female and five male. The average age of participants was 45 with a range from 34 to 54.

Table 3

Ethnicity, Age, Education, Diagnosis, Employment

Participant	Ethnicity	Age	Education	Diagnosis	Year Diagnosed	Months since Last Job	Longest Job Held in Months
Mark	AA	54	12	S	---	36	12
Suzanna	AA	50	12	S/BP	1983	384	8
Philomena	AA	54	11	MD	2013	NE	0
Alicia	NA	47	13	BP	1982	321	12
Stuart	AA	37	11	S	2003	72	4
Racheal	AA	50	12	S	2002	108	12
Edele	AA	36	10	BP/S	2000	NE	0
Robert	AA	47	12	S	1987	324	6
Winnifred	AA	54	15	S	1997	240	96
Jaqueline	AA	37	12	MD	2012	NE	0
Bridgette	AA	38	12	S/BP	2008	84	36
Tamika	AA	37	12	S	2003	108	6
Keith	Other	34	12	S	2008	60	6
Gail	H/AA	52	11	S/BP	1979	NE	0
Thomas	AA	50	10	S	2006	108	1

Note. (AA) African American; (H) Hispanic; (NA) Native American
(S) Schizophrenia; (MD) Major Depression; (BP) Bi Polar; (NE) never employed

Table 4

Age and Years Since Last Job Means, Job Tenure Median

Age ^a	Length since last job ^{ab}	Job tenure ^{bc}
Mean 45	Mean 13.9	Median 8 months
Range 34-54	(Range 3-32)	(Range 1- 96) months

Note. ^aIn years; ^bIncludes only those with a work history (n=11); ^c Median was used for job tenure do to the large discrepancy.

Overall, participants exhibited limited education and employment. Employment is reflective of any work that took place after the age of 18, the age considered to be a working-age-adult. The majority ($n = 10$) of individuals in this study were either never employed or never held jobs that lasted for as long as a year. Three individuals did hold a job for one year, and two individuals in the study held a job for more than a year, three years and eight years. One individual had a job prior to age 18 and is identified as never employed (NE). For those with a work history, median job tenure was 8 months (Table 4). Median was used as opposed to mean due to the large range from one to 96 months, or one month to eight years. The time that elapsed since last employed was varied and vast for most of the participants. Considering only individuals with a work history ($n = 11$), the shortest duration since last job was 36 months or three years. The longest duration since last employed was 32 years, a range of three to 32 years. Participants' work history indicates long term unemployment and overall short-term job tenure. Similarly, participants' education was limited.

Educational levels disclosed by study participants identified mostly basic achievements. Five individuals did not graduate high school, eight had a high school

diplomas, and one individual had one year of college. Additionally, one individual had a certification in a technical field, she had the longest job tenure of all study participants, eight years, although this was 20 years ago.

All participants were diagnosis with a serious mental illness for a duration of two to 33 years. Even though two individuals were diagnosed within the past five years, it became evident during the interview process that an illness may have been present for many years, but the individuals never sought medical help and were never officially diagnosed till recently. Schizophrenia was the most frequent diagnosis ($n = 8$). Two participants had Major Depression, and one participant was diagnosed with Bipolar. Four participants had been diagnosed with both Schizophrenia and Bi Polar disorder over the course of their illness. This switch contributed to an inaccurate original diagnosis leading to years on ineffective medication.

As described in chapter 3, grounded theory methods guided this study. The following sections describe the process of data collection, coding, analysis, and results as it took place during the study.

Data Collection

Data was collected via individual interviews, a background information form (demographics), observation, and researcher memos. Interviews lasted between 45 and 90 minutes and all interviews were recorded, with participant permission. A small, non-descript recorder did not seem to inhibit the open conversation with the interviewee. Interviews took place at a location familiar and comfortable for the participant. Interview sites included office space at a supported housing program, a self-help center, and a mental health day program. Spending time at each location provided me the opportunity

to observe participants in daily routines, to observe mental health staff and managers, and observe interactions between peers and professionals. Although interviews took place only once with each participant, I was able to additionally observe most participants as I spent many hours at interview sites. I was the sole researcher conducting interviews. Departures from the data collection protocol are discussed next.

One discrepancy of study protocol as described in Chapter Three was the elimination of the Participant Recovery Scale (PRS). After presenting this scale to the first three participants prior to the study interview, it became clear that the study participants gave more detailed and cognizant answers about their recovery during the interview, and PRS answers were vague and seemingly un-useful. Therefore, I illuminated the use of the PRS for the remainder of the study.

Additionally, five individuals that identified as eligible were later deemed unqualified because they had not been accurate about which Social Security disability benefit they received. This was not realized until after they completed the informed consent, completed the participant background data form, or began the study interview. It became clear after a more in-depth discussion with these participants that they additionally received SSDI benefits.

Data Analysis

Data analysis followed Charmaz's (2006, 2014) constructivist grounded theory stages of analysis. All interviews were transcribed in preparation for coding. Demographic data was compiled for analysis in an excel spread sheet. Coding began as soon as data transcriptions and demographics formatting were completed.

Coding. Three kinds of coding were used in this study, open, focused, and theoretical (Charmaz, 2006, 2014). This is consistent with a constructivist approach to grounded theory. Three independent researchers were employed as code examiners to help in assuring accurate and relevant coding. All three code examiners have conducted qualitative research and have experience in qualitative coding. Any coding discrepancies were resolved by discussion and consensus among code examiners and researcher.

Initial coding. Initial coding is the first step in making analytic interpretations of the data. Interview transcripts were imported into NVivo 11 Pro, a software program that supports qualitative research (NVivo, 2017), to assist with coding of the data base. Initial line-by-line coding created 78 initial codes, some in-vivo—using language taken directly from participants’ interview responses. Many of these initial codes included statements from multiple participants. A full list of initial codes is available in Appendix G. Additionally, samples of participant statements that fit into initial codes are exhibited in Appendix G.

Focused coding. Data was reunited by using focused coding. These focused codes were developed as initial codes began to show patterns and relationship identified by constant comparison of data to data and data to codes. Many hours were spent, coding, comparing codes to codes and codes to data, and recoding. Focused codes emerged by synthesizing the larger amounts of data identified as initial codes. Focused coding allowed me to move across interviews and compare participants’ experiences, actions and interpretations (Charmaz, 2014). Focused coding led to four categories and ten subcategories (see Table 5). The four categories emerging from focused coding are: 1) recovery, 2) so many barriers, 3) ambivalence, and 4) employment supports.

Table 5

Second Iteration of Focused Codes

Categories	Recovery	So Many Barriers	Ambivalence	Employment Supports
Sub Categories	Doing things differently	Lacking: Abilities Education Work history	Valuing the benefits of work: Employment is part of recovery but not necessary Work not a priority	Not knowing what I don't know or need
	Seeing the difference	Supplemental barriers: Minority Poverty Comorbidity	Not setting goals and not looking for work	
	Believing paid employment is part of recovery	Internal barriers: Negative past experiences Not believing I can		
		SSI's Impact on Employment: Fearing loss of SSI Doubtful of making enough to get off SSI I could work part-time		

Theoretical coding. Theoretical codes emerged as potential relationships between categories and subcategories were identified and deliberated. The theoretical codes not only identified relationships between categories but conceptualized my analysis in a theoretical direction. Three key theoretical concepts emerged and lead to the development of theory: 1) composite barrier, 2) encumbering reality, and 3) the

obstructive impact of ambivalence. Additional detail about the categories and theoretical concepts that emerged from the data is provided next.

Results of Analysis

The following discussion is organized according to the coding structure discussed above. Several iterations of focused coding took place leading to distinct categories and subcategories that both answered the research questions and lead to theory development. Appendix H represents an early iteration of focused coding. Table 6 represents combining related codes and the elimination of codes that did not sustain developing categories and subcategories. The following discussion begins with the four categories that emerged from focused coding: 1) recovery, 2) so many barriers, 3) ambivalence, and 4) supports. Categories are elucidated by a discussion of subcategories comprising each category. Participant quotes are interspersed throughout this section to further support the development of categories. Following this discussion, the theoretical concepts will be discussed. Finally, theory developed from this analytical process is presented along with a matrix.

Recovery. Although understanding recovery from study participants' perspective does not explain their enduring unemployment, identifying as *in recovery* is a key aspect of this study and does shed light on the findings. Standardized recovery instruments were not used; to qualify for this study participants self-identified as being in recovery.

The first two interview questions: "What is it like to be in recovery?" and "What does recovery mean to you?" offered some very interesting and insightful answers. Three sub-categories were identified as being part of the broader category recovery 1) doing

things differently, 2) seeing the difference, 3) seeing paid employment as part of recovery.

Doing things differently. Participants expressed a commitment to do what they feel strongly advances their wellness and recovery. Three contributing factors were identified by participants: commitment to taking medication, learning about their illness, and accepting support. The following participant quotes best describe these beliefs.

Bridgette: “I was never diagnosed before and they just gave me drugs that made me feel not like myself. I told them I could function without them, which I did for a while. Now I see a difference.”

Tamika struggled many years with mental illness and drug and alcohol abuse, becoming justice involved before being diagnosed with schizophrenia.

It’s [recovery] like healing. Healing from a virus or an infection or a trauma. By taking medication, going to groups, getting active in the community and interacting with my family. [I] got treatment...they put me on medication. I got counselling. Then I got housing. I’m still getting treatment, taking my medication, and I’m working on getting a job... If your medication is working, you will be pretty much okay to work.

Winnifred, 54 years old, was employed for 8 years. However, her employment was 20 years ago, which coincides closely with the time she was first diagnosed. She describes her recovery as a restoration:

It’s [recovery] like being resilient or in restoration. You can bounce back. If you take your medication and follow the procedures and try not to be stressed. I was angry when I was first diagnosed, when I calmed down from being angry that’s when I started coming around....if you stay on your good side of you you can be healed. If you stay with your good conscience and practice every day, try not to be upset and you can come out as a winner.

Thomas, age 50, has a tenth-grade education and was diagnosed in 2006. He relates his recovery to learning about his illness and medications:

It's a good thing to learn about the mental illness that you are diagnosed with. It's good. You learn about the medication you are taking. There is so much you learn about it. I can't say anything bad about it [recovery].

Alicia, age 47 concurs. She was diagnosed in 1982, but did not begin receiving SSI benefits until 2010, when she could afford and accept treatment. "Well, [in recovery] you have to get all the knowledge that you can about your illness. I'm dual diagnosed so I have DNA [drug and alcohol] issues as well as mental issues and my recovery is paramount for me".

Seeing the difference. The outcome of being in recovery provides real discernable differences in the lives of participants compared to prior to recovery. Participants spoke about being able to do things they couldn't do before, and about being accepted by others. It was observed that participants' countenance and overall affect exhibited pride and joy over what they were now experiencing.

Participants see recovery in what they are now able to do or will be able to do as compared to before recovery. Some of the things participants can do now, but were not able to do before recovery, shows how devastatingly their illness impacted their life. Mental illness affected basic activities, e.g., basic as cooking, cleaning, washing clothes, getting out of bed, managing finances, taking a shower, interest in hygiene, getting active in the community, and interacting with family.

Robert, age 47, has not worked in over 25 years, which is about the time of his diagnosis. His description of recovery emphasizes the struggle he has been through, and how grateful he is to be in recovery:

Being grateful and able to face the day and showing gratitude... Just being grateful and reading the *Bible* and being happy to have food in your stomach and clothes on your back, a roof over your head. Just not having relapses, not landing

back in the hospital, not landing in jail. Just being worry free, not worrying about suicide or anything like that.

Racheal, age 50, was diagnosed in 2002 and has not worked in nine years. She expressed how more is possible for her now that she is in recovery:

Recovery means that I could go back to school. I could buy a car. I could get a home. I could get a job. No, they didn't [seem possible] because the mental health problem and my drug addiction problem wasn't working.

Alicia who also dealt with drug and alcohol abuse and a prison sentence expresses the rewards of recovery: "It [recovery] means making your quality of life better...It makes you feel like a more productive member of society. It gives you a better sense of self-worth, inner being. It has its rewards."

Gail, aged 52, was originally given the wrong diagnosis and medication. It took almost 30 years before she was given an accurate diagnosis and put on medication that worked, paving the way for her recovery. She puts a positive spin on her illness and is able to express how her life has changed for the better:

I don't call it an illness or a sickness. I call it an issue or a problem in my life that has come a long way because I was real sick. I take my medicine faithfully and my recovery is terrific. I feel good about myself, I feel confident and I feel happy. It means I still have a chance at life.

Tamika, age 37, has not worked in nine years. She ties together two benefits of recovery: doing things she couldn't do before and being accepted by others.

In my recovery, I can do things now. I can do the things that I'm supposed to do as a human being and function. Doing things that I couldn't do before, feeling like a human being, being accepted by other people.

A sense of how participants were treated by others before recovery became evident as they talked about their experiences.

Edele, age 36, was diagnosed in 2000 at age 21, and has never been employed. She talks about how she was treated because of her mental illness: “People look at you differently when you have an illness, they make fun of you, they talk about you and they belittle you. They put you down because you’re not like the rest.”

Alicia, age 47, last worked when she was 20 years old, is able to link how she was treated with not being employed:

I didn't work for 20 years, because I didn't want to be embarrassed, just leave it at that. I didn't want people looking at me funny and I didn't want to snap out on somebody for saying the wrong thing to me or “did you take your meds today”?

Gail, age 52, was originally diagnosed in 1979 and was never employed as an adult. She is able to portray what it feels like now to be in recovery, and what she must have experienced in the past:

For me being in recovery from mental illness is a great thing because I feel like I belong to society. I feel like I'm not made fun of. I feel like I don't have a stigma on me and I feel like a person instead of being idolized, not idolized, but picked on and talked about, criticized because of my illness. Yes, part of my recovery is that I feel accepted. I feel joy because I know that I can cope with it now.

Winnifred expressed acceptance in a similar way. “It [recovery] means that you are accepted in society. It means that I am like other people.”

Acceptance as part of recovery also includes self-acceptance. Racheal, talks about being able to accept and love herself now that she is in recovery:

Yes, [medication] and the affirmation about my mental health and the coping skills that I learned, that I'm a person just like anybody else, that I don't have to feel down because I have a mental illness...I'm learning to love myself and who I am, accepting myself the way I am.

The second category identified during focused coding, so many barriers, is discussed next. This is followed by the last two categories ambivalence and employment supports.

So many barriers. Barriers is a term I am using to identify aspects in a study participants' life that negatively influenced the ability to get and keep employment. Participants did not use the word barrier or identify life experiences as limiting their ability to gain employment. The identification of what I am calling barriers arose as they told their stories and the data was analyzed.

It is striking to identify the multiplicity of barriers that negatively impact an individual's ability to find employment, not to mention, pays enough to get off SSI. Each of the study participants had multiple barriers arising over time, compounding the effects (see Table 6). Details of how each barrier arose due to SMI is not addressed in this study, but this study does make evident the heavy contribution of SMI on employment. I will now discuss the four broad subcategories that provide structure to the category titled so many barriers: lacking, supplemental barriers, internal barriers, and the impact of SSI on employment.

Lacking. Having limited education, limited or no work history, and a lack of abilities makes it very difficult to compete as a job candidate. Additionally, lacking these vital attributes contributes to an individual's belief that they are unlikely to be hired. Study participants acknowledged their limited education, limited work history, and belief that they did not have the abilities to be competitive in the job market.

Supplemental barriers. Additional barriers experienced by this cohort of individuals include their minority status, comorbidity of mental health and other conditions, and living in poverty. One study participant identified his race as *Other*; it is not known what ethnic background he represents, or if his apparent ethnicity would impact his being hired. The other study participants identified as African American,

Hispanic or Native American. In the fourth quarter of 2017, the unemployment rate for whites was 3.1%, for African Americans/Blacks it was 6.4%, and for Hispanics/Latino it was 4.3%, showing a higher unemployment rate for minority individuals (BLS, 2018).

Many participants identified the additional barrier of having co-occurring conditions including carpal tunnel, bad knees, personality disorder, developmental disability, drug and alcohol abuse, and post-traumatic stress disorder (PTSD). Living in poverty is an additional barrier for individuals seeking employment, e.g. not having enough money for transportation or appropriate clothing for an interview. SSI benefits are below the poverty level in all of the United States.

Internal barriers. While telling their stories, several participants identified internal struggles, doubts, and fears.

Racheal does have a high school diploma, however, with limited work experience and no additional training, doubts she would be a strong candidate for getting hired.

My work history was really poor. I worked a ton of jobs, some for a couple weeks, some for a month, two months, three months...these days with the computer and all this technology going on a college educated person would get it before me. So that means I would have to be prepared and would have to have more than just look, I need a job. I don't have no skills. Like, what kind of job would take a person these days who don't have a skill? I don't know of any. I guess part is doubting myself, not having a 100% like I can do this, I can do this. I don't have any college education, I don't have training, I don't have an Associate's. All I have is a high school diploma.

Suzanna, who has not worked in over 30 years, doubts being hired and fears the potential rejection: "Would they hire me, would they take me knowing my background and everything? The rejection, I know how to interview, I know what to do. It's just that, would they hire me?"

Table 6

Multiple Barriers

Participant ^a	Age	Education, 12 or less	Long term Mental Illness ^b	Time since last job ^b	Longest Job tenure, one year or less	Entry level employment	Comorbidity	Receiving SSI ^c	Minority	Under Poverty level
Mark	54	✓	—	>3	✓	✓		✓	✓	✓
Suzanna	50	✓	> 30	>20	✓	✓	✓	✓	✓	✓
Philomena	54	✓✓*	>15	>20	✓	NE		✓	✓	✓
Alicia	47		> 30	>20	✓	✓	✓	>5	✓	✓
Stuart	37	✓✓*	>10	>5	✓	✓		>10	✓	✓
Racheal	50	✓	>10	>5	✓	✓	✓	>15	✓	✓
Edele	36	✓✓*	>10	>20	✓	NE		>15	✓	✓
Robert	47	✓	>25	>10	✓	✓		>20	✓	✓
Winnifred	54		>15	>10			✓	>7	✓	✓
Jaqueline	37	✓	>3	>20	✓	NE	✓	✓	✓	✓
Bridgette	38	✓	>7	>5		✓		>20	✓	✓
Tamika	37	✓	>10	>5	✓	✓	✓	>7	✓	✓
Keith	34	✓	>7	>5	✓	✓		✓	✓	✓
Gail	52	✓✓*	> 30	>20	✓	NE		✓	✓	✓
Thomas	50	✓✓*	>7	>5	✓	✓	✓	>7	✓	✓

Note. (NE) never employed; ^aAll names are pseudonyms; ^bIn years; ^cIf known, years on SSI given; *✓✓ specifies less than 12th grade education.

Robert, age 47, has not worked in over 20 years. He fears making too much money and losing his SSI benefit, which would lead to being homeless and destitute. He has also faced not being hired because of his limited work experience:

I don't have experience and I'm not business savvy to hold down a job right now. Because I'm afraid if I make a certain amount of money I'll be out on the street. Only thing that I get nervous about is losing my benefits. I don't want to wind up homeless and destitute. I had worked here, I had worked there, and they said you don't have enough experience to work here. So, they didn't hire me.

Gail expresses a mix of thoughts and emotions around becoming employed, leaving her comfort zone, relapse, not being able to keep the job, and being stigmatized:

I don't know because I feel comfortable at program name and at home but if I'm around a crowd of people I get real nervous. If I get a job I might not keep the job if I have a relapse. The most important thing to me is knowing that I could do the job, knowing that I could cope with the job without getting sick, and being accepted. Just being treated as a normal person and not being stigmatized because I am mentally ill. I don't want to seem like I'm mentally ill when I'm on a job. I want people not to look at me and say oh, there's something wrong with her. Because I can function like a normal person. To me, if you look at me and say you don't know me and you don't know if I'm mentally ill or not. How can you put a tag on somebody when you don't know? I think if I got a job, I could really do it as long as I'm not being criticized and picked on. That hurts my feelings.

The impact of SSI on paid employment. Study participants identified three primary effects of receiving SSI on their employment pursuits: fearing the loss of SSI, doubting that they can make enough to get off SSI, and considering only part-time work.

Gail, age 52, has never been employed. She articulates her feelings around SSI and work to include her fear of getting sick again, loss of SSI, and the unfairness of having her money taken away in the pursuit of bettering herself:

I think for me, SSI is lacking by not letting me get a job. They would take away my check if I get a good job. They should understand that I could get sick at any time. I think they won't take your check all at once. They take it slowly until they see you can keep the job. But if I was to get sick I know for a fact that I could get

it back. I had a friend and that happened to her. I still have concerns because I don't think it's right that they take away your money if you get a job and try to better yourself. You are trying to show them that you can cope with life and try to live a normal life and get a job.

Although Bridgette states SSI does not prevent her from looking for work, it has been 7 years since her last job. She has some awareness of the SSI work incentives and states she has been looking on-line for part-time work for the past month. She feels her family would support her becoming employed. Nonetheless, there is the underlying fear that she will lose her SSI benefits:

Being on SSI would not prevent me from looking for or getting work. It would prevent me from getting full time work. My concern is I'm trying to meet their criteria. You can't make over an amount, you have to make enough to get you through the week but you can't go over an amount for the month for the check requirements...My family wants to see me employed, somewhat. Because they don't want me to make so much money that they take my check away from me completely. They're concerned about my losing my SI check. They would be worried that I would get fired or something like that.

Bridgette who worked full-time for 3 years, can no longer picture herself working full-time. She additionally states “[I] don't picture myself or have plans to get a job where I can make enough money and not need SSI...[I] don't ever picture myself being employed full-time.”

Winnifred, who at one time worked for eight years, doubts she would now be able to make enough to get off SSI, unless she worked two jobs:

I believe if I worked two jobs I might be able to make a good amount so that I could provide what I made on Social Security. I believe that if I get the right job I can get off of SSI. But it has to be paying what SSI pays me or more. I'm on a budget and I know the amount that I get is what I survive with. If I was to get a job making the same amount I would be able to survive.

Robert clearly ties in full-time work and the loss of his SSI: “Part-time for now, 20 hours per week. If I was on full-time I would definitely lose some of my benefits.”

Tamika acknowledges working part-time is a way to keep her SSI: “I would like to work part time so I can keep my Social Security check.”

Edele, age 36, has never been employed. If she does pursue employment, it would be part-time:

I think I would start part-time. Because I won't be able to have a full-time job because I'm on SSI. They told me I can't work more than 20 hours. I'd rather work part-time first and then work my way up. Because I don't know how I would do in a full-time job. The recovery coaches told you the same thing as the Social Security office, about working the 20 hours.

Racheal is aware that SSA has work incentives that assist SSI recipients with returning to work. She can picture herself employed and getting off SSI at some point, however has been on SSI for almost 20 years and unemployed for over 10:

I can only work part-time being on SSI. I think that comes out to 20 hours a week that I can work and get my check even though SSI subtracts from my check or however much applies at the time...I don't know the ins and outs of how long I can be on SSI. I've already been on it since 1998. Here it is 2015. So, I'm still unsure. Yes, I can picture myself working full time and getting off SSI, but I think I would start part-time.

Ambivalence. The makeup of the two subcategories establishing the ambivalence category, mingled with the accumulation of barriers, helps explain the ambivalence participants experience concerning actively pursuing employment, and begins to explain enduring unemployment. Ambivalence subcategories combines the discrepant beliefs of study participants: 1) valuing the benefits of work, 2) not setting goals and not looking for work.

Valuing the benefits of work. Despite seeing paid employment as part of recovery and valuing its benefits, employment was not seen as necessary to recovery, and it was not a priority. All except one study participant (n=14) definitively stated that paid employment is part of recovery. Admittedly, the interview question was closed ended

asking “In your opinion is paid employment part of recovering from mental illness?” They were then asked to elaborate on their answer.

Initial answers were brief and affirming. Stuart answers, “Yes, I want to go back to work one day.” Winnifred recognizes the benefits of employment in promoting recovery, “Yes [paid employment is part of recovery]. It will make you responsible and it triggers off your conscience. It makes you happy when you receive a paycheck and be able to purchase and do things.”

Gail links employment and recovery because of the extra money and as a means to help one cope and strive for more:

I think paid employment as part of recovery is good because you have some money to spend and do the things you need but I volunteer and I do get a little something from that. I think the job itself helps you cope with things and makes you want to strive more.

Increased income was the greatest incentive for employment. Besides a paycheck Tamika hints at the recovery benefit of work, she states: “You can pay your bills, you can buy different things for yourself and your household and just earn a decent living. It gives you something to do instead of concentrating on your mental illness. Saving money, build credit.”

For Racheal, age 50, recovery includes getting a job. She affirms employment can be part of recovery: “Recovery means that I could go back to school. I could buy a car. I could get a home. I could get a job. It [employment] most definitely can be part of recovery.” Later in the interview she clarifies that being in recovery would be enough for her even if she didn’t get a job. This conflict was expressed by other study participants. Even though participants value work, and state they would like to work at least part-time, employment is elusive.

Not setting goals, not looking for work. Eleven of the 15 study participants definitively stated they are not setting goals to work, nor are looking for work. This is incongruent with their belief that they could work at least part-time.

Thomas who identifies as being in recovery and states that paid employment is part of recovery, also states he is just thinking about work:

Yes, I think it [paid employment as part of recovery] is. For me it is but I don't know about anybody else. I can't work at this particular time but I'm thinking about going back to work...When I think I'm really decided to go back to work, I will consult with my case worker and find out what I need to do go get into the work field and then we'll go from there.

Winnifred, age 54, has not made up her mind about returning to work after 20 years of not working. She identifies herself as resting:

I'm resting. I just need some time...I'm just thinking about getting my loans paid down from going to school. I'm resting right now but once I make up my mind, I'll go forward and get a job. I don't know. I'm uncertain about getting a job right now...No, I'm not 100 percent decided. So-so, in between.

Racheal, who talked about work being part of recovery, verbalized that she hasn't made a decision or set a plan to work. She would like training or education to acquire what she perceives as that perfect job. However, she was unable to describe what a perfect job is. This lack of clarity may impact her follow through:

I guess just not being clear on a plan. I guess part is doubting myself, not having a 100% like I can do this, I can do this. My caseworker mentioned that she had applications about training but I just didn't follow through with it, not yet. It's just not time for the doors to open up for me... no I haven't [made the decision to work]. I have a daydream of a perfect job but I don't know what that is yet. I don't know what it is that I want to do. I've been through trying to understand the college thing a little bit, calling schools but I still don't know what it is I want to do with my life. I do want to be able to have an occupation or career that helps me.

Keith, age 34, envisions what he would say if he went to work and no longer needed to receive SSI benefits: “Oh yeah. One day I just want to tell the government to keep your money, I don’t need it.”

When asked about the possibility of employment now or in the future, Suzanna, who is 50 years old, states she is thinking about work, “in the future, part-time. I don’t know. The next maybe ten years or so. I don’t know. Maybe before that, maybe in five years.”

Stuart, age 37, states he wants to go back to work, but identifies other priorities:

Yes, I’ve thought about it. I want to go back to work one day. I want to get employed. As soon as I get my education [high school diploma] and I get a house. I still have a couple other things to get myself ready for employment.

Four participants were presently looking for work. Joquette is seeking work for cash. Edele, Bridgette, and Tamika state they were looking for work on their own and did not seek help from anyone. Their job searches were limited, and employment has not been forthcoming. Bridgette was looking for work by using the computer at her mental health program but has not been out in the community applying for jobs.

Edele, who has never been employed, is looking for work in her community. She did not ask for assistance in her job search and is unaware of where she could get help or what help she would need. So far her job search has been ineffective: “They keep telling me since I don’t have a high school diploma they won’t hire me. They say they are going to call me but they never do. I think they just say that to shut me up.”

Tamika states she applied for work at a temporary agency but didn’t like the shifts she was asked to work, and never went back. She also applied at a grocery store, but too much had time passed before she followed up:

I put in an application over 90 days ago. I just called them and they told me to put another application in because they received a lot of applications and they weren't able to look at all of them. So, they told me to put in another application in.

Tamika feels supported by her mental health professional who knows she is looking for a job. Her mental health worker believes college would provide better paying employment options and is "helping me fill out applications for college, we haven't finished." She goes on to say, "I'm getting the help that I need."

Employment supports. It became clear that participants felt encouraged, and were receiving emotional support from mental health professionals, both in regards to their mental health and in regards to employment. Study participants stated they were or would be supported by mental health professionals when they made the decision to work. Employment supports were limited and sporadic.

Racheal provides an example:

Program name is a great support for me...Since I've moved into my new independent housing, I have a case manager. My mother's a great support and the groups I go to here are very informative. I try to participate and taking information as well so I don't forget those things when I'm not here... Student intern name who was here in this office for a couple of weeks as an intern, she started me with some sort of resume. But we never got through it...My counselor from mental health program took me through a questionnaire to see what my likes and dislikes are, things like that. That is as far as we got so far.

Robert felt differently about being supported, in regards to employment, by his mental health worker:

She [mental health professional] probably doesn't want me to work right now. When I started coming here last year she said she was going to put me into supported employment but I never got put in there. She has a lot of people in her case load and probably didn't have the time. Maybe that's why I never went but I would like to go to supported employment. I would like to fill out applications and go for interviews. That would be good. That would be good to have somebody shadow you when you go on interviews and telling you what you're doing good and how you're doing. They feel like basically I could get

unemployed, lose my job. They don't want to see me destitute. They don't say that to me. I just get the feeling.

Pre-employment groups were available at some mental health programs where participants attended. Gail attends a program where employment groups were offered:

They ask me if I am able to work, do I think I am able to function to work, would I like to work? They encourage me... She [mental health professional] asked me if I want to go back to work. We have peer employment groups that...encourages people to get jobs. We have a handbook here that talks about jobs...It tells you how to get a job and what you go through trying to get a job if you have a mental illness.

Thomas also attends a program that offers job prep: "They have a class at mental health program now to prep you for a job. They do resumes and act out an interview. You come in and they ask you questions. It's a pretty decent program."

Even though participants speak highly about the value of employment, they were not choosing employment. For those looking for work they have thus far not been successful in gaining employment. This lack of deciding to work or gaining employment highlights that the support they are receiving may not be adequate. The following illuminates what support study participants felt they were receiving and their limited insight into what additional supports could best assist them with getting and keeping employment.

Not knowing what I don't know or need. Interview questions exploring what participants felt they need, what others need to know and do, and what changes would benefit their becoming employed, were included in this study with the belief that study participants could inform the field of psychiatric rehabilitation and SSA. The findings contradicted this expectation. Participants had limited insight into what was needed for them to choose and gain employment. Participants were able to identify some things,

such as needing training, resumes, access to applications, and more information, particularly in regards to the impact of employment on SSI. However, they did not have a deep knowledge of what supports would help or were available.

Answering second level research questions. Table 7, supported by Appendix I, brings this study analysis closer to theory development. Table 7 represents the iterative process leading to answering the overarching research question, and sub-questions. The research questions that drove this study are represented in Table 7 by RQ then the question number. Under each of the research questions (RQ), reading from the bottom up, initial coding is grouped into focused coding, then patterns/categories, then answers to the research questions. By organizing data in this way theoretical categories emerged from the data. To reiterate research questions, they follow:

Overarching research Question:

What leads to the enduring unemployment of individuals in recovery from mental illness who are receiving SSI?

RQ 1: What is the process that leads to continued unemployment of individuals in recovery from mental illness?

RQ 2: What factors identified by individuals in recovery from mental illness contribute to their unemployment?

RQ 3: How does paid employment fit into the definition of recovery for individuals in recovery from mental illness?

RQ 4: How do individuals in recovery from mental illness make the decision to work, or remain unemployed?

RQ 5: From the perspective of individuals in recovery from mental illness, what needs to happen for them to choose employment?

Explaining Enduring Unemployment, Theory Development

What follows is the expansion of theory that explains the enduring unemployment of individuals in recovery from mental illness receiving SSI. The relationship and interaction of the theoretical concepts set the foundation for theory that addresses this phenomenon (see Figure 3). Four theoretical concepts are used to build theory 1) composite barrier, 2) encumbering reality, 3) the obstructive impact of ambivalence, and 4) someday dream.

Composite barrier. The years lived by study participants, prior to their identified recovery, is a prime contributing factor in the development of multiple barriers. While each barrier standing alone has the potential to impact employment outcomes, for this cohort of individuals, barriers cannot be separated and addressed individually. The term multiple barriers does not express the same inclusiveness and breath of these compounding barriers. What has become evident from this study is that barriers became a composite, or amalgamated barrier. The word amalgam helps in comprehending that a composite barrier is a mixture of barriers creating a newer, stronger barrier than an individual mix of barriers. A composite barrier exhibits an amplification of the negative impact on employment outcomes. This composite barrier leads to and adds to the second theoretical concept, encumbering reality.

Table 7

Code Mapping: Three Iterations of Analysis to Answer Research Questions (to be read from the bottom up)

Theoretical Concepts				
Composite Barrier; Encumbering reality				
The obstructing impact of ambivalence, Someday, Not making a conscious decision				
Answering Research Questions				
<u>Answering RQ1</u>	<u>Answering RQ2</u>	<u>Answering RQ3</u>	<u>Answering RQ4</u>	<u>Answering RQ5</u>
Compounding Barriers, growing Ambivalence, Needing More support	Compounding barriers, both internal and external	Paid employment is seen as part of recovery, but not necessary	Work is possible, but I remain unemployed, Not a conscious decision	Needing information & education, Don't know
Pattern Variables/ Categories				
Barriers Discrepancy Ambivalence Receiving help vs not	Barriers to Employment Multiple Internal Passage of time	Recovery Employment as part of recovery Valuing employment	Discrepancy Ambivalence SSI and paid employment FT vs PT	Needs Others need t Not knowing what I don't know
Focused Coding				
Ambivalence Not doing it Deciding Discrepancy Not a goal Passivity No plans Not looking Thinking Unsure Help vs no help	Lacks skills Lacks education Lost years Work history Job tenure Symptoms Fear of rejection Thoughts and beliefs Fears Keeping job Experiences	Information, support as part of recovery Employment and recovery The other side Benefits of employment Money SSI is not enough	Impact on Employment Not believing in getting off SSI Not wanting to be stuck on SSI Not wanting to lose SSI SSI as a stepping stone FT vs PT	Information Help Education Training Need to do SSA needs to know Case managers need to know

Note. adapted from “Qualitative Analysis on Stage: Making the Research Process More Public,” by Anfara Jr., Brown, & Mangione, 2002. *Educational Researcher*, 31(7). Copyright 2002 by the American Educational Research Association; reproduced with permission of the publisher.

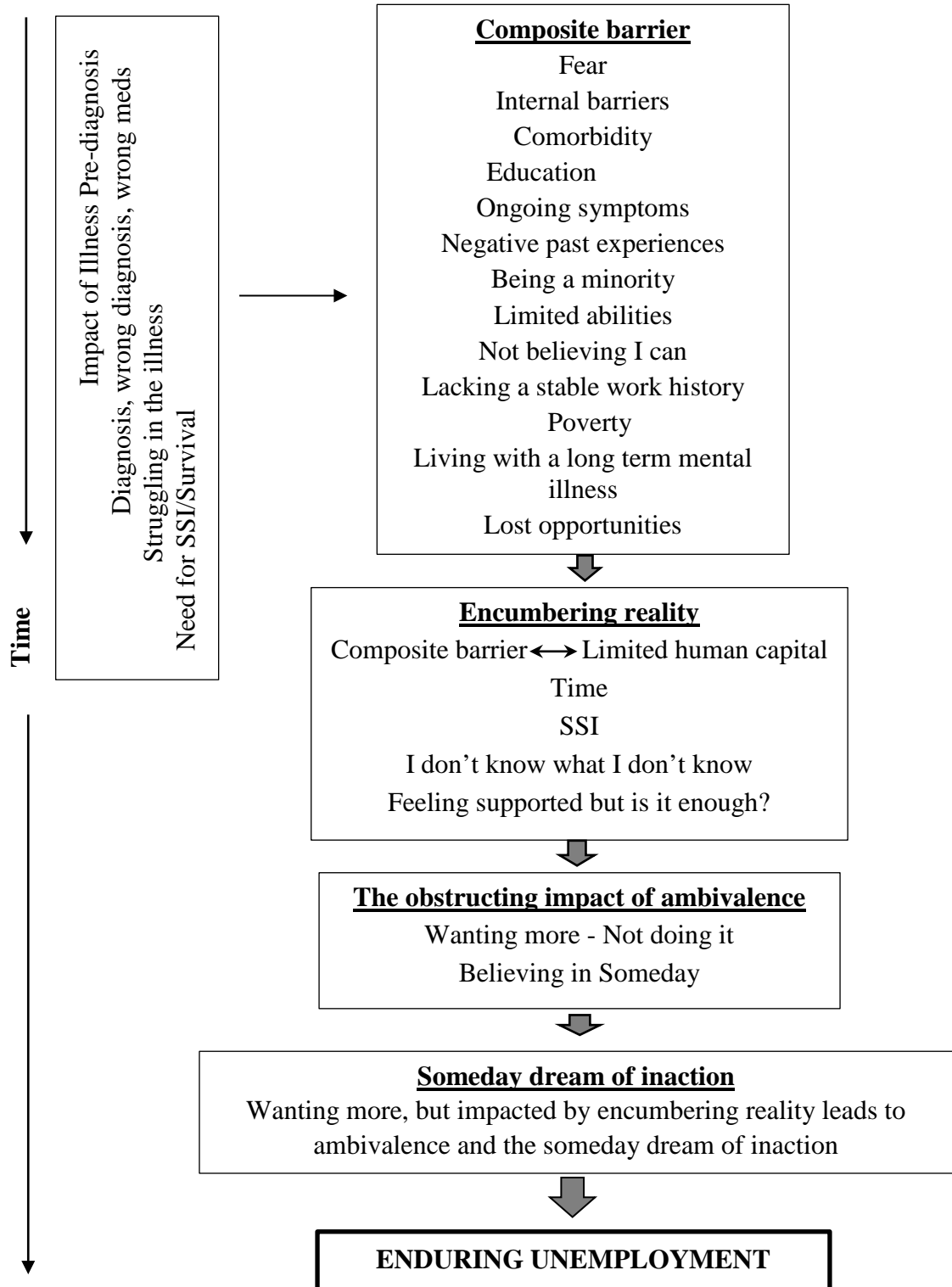


Figure 3. Theoretical Matrix

Encumbering reality. Study participants experienced a combination of events and circumstances that impact their employment outcome. Like a composite barrier, additional factors combined and contributed to an encumbering reality. The encumbering reality includes the composite barrier, which limits human capital, the passage of time, receiving SSI, and not knowing what is needed to escape this encumbering reality.

Limited human capital. Two aspects of this theoretical concept interact and contributes to strengthening the negative influence of the other, composite barrier and limited human capital. Human capital in relation to this study is defined as:

The collective skills, knowledge, or other intangible assets of individuals that can be used to create economic value for the individuals, their employers, or their community. [Economics] The abilities and skills of any individual, esp. those acquired through investment in education and training, that enhance potential income earning (Human Capital, 2018).

A composite barrier limits the building of human capital, a necessity to gain substantial employment that pays a living wage, and this limited human capital becomes more influential and limiting as time passes.

Time. An additional aspect identified as part of encumbering reality is the passing of time. The concept of time plays a vital role in theory development from this study, what has passed, what's taking place now, and what the future holds. The participants who took part in this study were between the ages of 34 and 54, and only recently identified as being in recovery. Their 20's, and for some, their, 30's, and 40's, are gone, a time when most people are building their human capital. Instead the composite barrier was developing and strengthened.

Between 16 and 36 years of study participants' adulthood have passed. These years cannot be recovered. As the researcher I wanted to identify them as *lost years*, but

this term was not used by any of the participants. For those in their 30's there is still time to build their human capital, get a college degree and build a work history. For those in their 50's, time is limited until they can identify as retired. This is not to say that employment, even substantial employment, is not possible for any of the participants. The fact that passing time is an encumbering reality still remains.

The impact of receiving SSI. Participants spoke about paid employment in very positive terms. Income from employment, so they could do things they couldn't do now on SSI, was the primary inspiration. Yet, fears of losing SSI if they went to work and doubts that they could find work to pay enough to get off SSI were evident.

I don't know what I don't know/feeling supported but is it enough? Fourteen of the 15 participants stated they were, or would be, supported by their mental health professional in regards to employment. Yet, only four were looking, and their job searches so far were unsuccessful. If work is seen as valuable and as part of their recovery and they are living in poverty on SSI, the question "What else is needed?" begs for an answer. Other than basic ideas of their needs, participants were unable to identify what would affect real change for them to choose and seek employment.

Obstructing impact of ambivalence. Ambivalence appears to play a large part in the enduring unemployment of study participants. Study participants talked with animation about having a larger income and being able to do more in their lives. However, the majority of study participants ($n = 11$) were not actively setting employment goals or looking for work. There was a paradox between their thinking and their action identified as ambivalence towards becoming employed. Participants

envisioned more in their lives with future employment but weren't taking the steps to make it a reality. I call this the someday dream of inaction.

Someday dream of inaction. Study participants desire increased income but they are impacted by an encumbering reality that leads to ambivalence and the someday dream of inaction. Study participants envisioned more for themselves than a life in poverty. Work was seen as a valuable avenue to reach their envisioned future. However, a composite barrier, encumbering reality, the passage of time, and not knowing what other supports they need leads to their ambivalence about work. Not wanting to give up their dream of a better future, participants are able to accept their encumbering reality by holding on to a someday dream.

Conclusion

In this chapter the findings from the research of the enduring unemployment of individuals in recovery from SMI, receiving SSI were presented. Additionally, theoretical analysis and concept development were conveyed, followed by theory development explaining participants enduring unemployment. In summary, I will first recap with a brief review of the main points of the chapter. To conclude, I will cap answers to the five research sub-questions, followed by the overarching research question, which is answered by the developed theory.

All study participants attended and were interviewed at mental health programs that provided them support, or treatment and support for their mental illness. Participants were between the ages of 34 and 54, living between three and thirty years with a mental illness. Now, in recovery, they have accumulated multiple employment barriers diminishing their status as a competitive job candidate. SSI benefits, a necessity for

survival when in the throes of their illness, has become another impediment to employment. Ambivalence in deciding to seek and gain employment and its benefits and the risks of becoming unemployed, additionally interferes with study participant's decision to work. Although, they feel they have the support from mental health professional in their work decisions, it is questioned if what they are receiving is adequate to overcome all that stands in the way of these study participants and work. Answers to the study research questions, supported by findings, follows.

Research question 1. What is the process that leads to continued unemployment of individuals in recovery from mental illness? After diagnoses of SMI, study participants often spent years struggling with their illness before beginning their recovery process. These years lead to compounding barriers, later in the analysis identified as a composite barrier. Combined with this composite barrier, other realities encumbered participants from choosing work. Participants' speak highly and animatedly about the value of paid employment yet experience ambivalence when faced with making a decision to work. Their ambivalence positions employment at an unknown point in the future, allowing for the delay in planning and action. Participants' additionally lack insight into what may support them in moving forward towards employment.

Research question 2. What factors identified by individuals in recovery from mental illness contribute to their unemployment? Participants identified multiple elements contributing to their unemployment. They were aware of lacking sufficient abilities, education, and work history, which weakened their position as competitive job candidates. Potentially adding to their unemployment, all participants identified as a minority and lived below the poverty level. Seven of the study participants additionally

had comorbid conditions, e.g. bad knees, PTSD, a personality disorder. Participants had several internal beliefs that contributed to their unemployment.

Negative past experiences associated with employment, such as being stigmatized by employers and coworkers, and fear that something bad would happen if they became employed were identified. The potential of again being treated poorly, ridiculed and stigmatized continued to feel real for some participants. Fear of rejection, not being hired, or lack of belief in themselves, were strong deterrents for others. Most study participants did not recognize the contribution of SSI to their unemployment. Yet, they were able to identify their fear of losing SSI if they went to work and their doubt that they could ever make enough to discontinue receipts of SSI benefits.

Research question 3. How does paid employment fit into the definition of recovery for individuals in recovery from mental illness? Paid employment was definitively seen as part of recovery by 14 of the study participants. The benefits of employment related to ongoing recovery, such as feeling good about one's self, having a reason to get up in the morning, and keeping one's mind occupied, were all identified as benefits of employment. Participants stated additional money through employment would contribute to their recovery. Additional income would allow participants to buy and do more things, and potentially contribute to savings. All these were seen as ongoing parts of recovery.

Research question 4. How do individuals in recovery from mental illness make the decision to work, or remain unemployed? Irrelevant of the strong conviction that paid employment is seen as part of recovery, it was also identified as not necessary to recovery. Participants were not able to rectify this discrepancy. This discrepant thinking

and perceived ambivalence cultivated the conclusion that overall, study participants were not making conscious decisions to work.

Research question 5. From the perspective of individuals in recovery from mental illness, what needs to happen for them to choose employment? Participants know that additional training or education, and information would contribute to their employability. However, they are not necessarily seeking these. Participants did not have an in-depth understanding of what can, if anything can assist them in choosing work.

Overarching research question. What leads to the enduring unemployment of individuals in recovery from mental illness who are receiving SSI? This overarching research question was answered by the development of theory explaining this phenomenon. Participants stated that employment and the larger income it offers would contribute to their recovery. A larger income would increase their ability to have and do more but the encumbering reality of a composite barrier, limited human capital, the impact of SSI benefits, and their own ambivalence has interfered with their employment pursuits. By envisioning employment as in the future, a someday dream, their inaction becomes acceptable to them.

In the next chapter I will discuss the findings and implications related to the research questions and literature used in this study. Further, I will discuss recommendations and limitations of my study, and conclude with suggestions for future research.

Chapter 5

Discussion, Recommendations, Implications, and Conclusions

Using an interpretive grounded theory approach, that incorporated a constructivist view, this study explored enduring unemployment of working aged adults—age 25 to 54—in recovery from MI and who receive SSI. Participants' views of recovery, employment and SSI were explored. Additionally, participants identified key factors that hinder employment outcomes. Data analysis concluded with development of a substantive theory to explain this phenomenon. By gaining a deeper understanding of the process that leads to enduring unemployment and using the emergent theory mental health professionals and policy makers can develop more effective strategies and procedures to address underlying causes of enduring unemployment.

Purposeful sampling was used to meet the above-mentioned study criteria. Fifteen study participants completed the semi-structured interview protocol. Interviews lasted between 45 and 90 minutes and were conducted at program sites where participants attended—supported housing, day program, or wellness centers. Each site provided a quiet and private office space to conduct individual interviews. Data collection included demographic information, digitally taped interviews, observations, and field notes. Grounded theory methods guided data collection, data analysis and theory development.

Chapter 5 covers several areas of interest and is organized as follows. First, I will present why this research matters. Second, I will discuss how findings are situated in existing literature. Third, I will present the limitations of this study, and personal biases and assumptions that may have influenced study findings. Fourth, I will discuss implications of the findings for multiple stakeholders, including study participants,

service providers, and policy makers, both within the profession of mental health and government. Finally, I will suggest recommendations for future areas of research.

Importance of Research

Without the advantage of working in a job making a living wage (Glasmeyer & MIT, 2013)—making enough to support one’s self—individuals with MI are most often left to a life of poverty and dependence on governmental support (Baron & Salzer, 2002; Marrone & Golowka, 1999). For those who receive SSI the monthly benefit amount falls below the U. S. federal poverty level (Danziger, Franck & Meara, 2009; SSA, 2018). While individuals with SMI living on SSI are not left without some sustenance, a social justice issue is present and evident. Acceptance of U.S. policies that tolerate poverty, and provide limited opportunities to escape from poverty, need to change. This study contributes to a greater understanding of issues from the study participants’ perspective. With this understanding, findings will contribute to the development of more effective service provision strategies and more effective policies addressing the long-term and persistent unemployment of individuals in recovery from MI, receiving SSI. Equally as important is the understanding and acceptance that employment plays a vital role in recovery from mental illness (NAMI, 2014a).

Discussion of Findings as Situated in the Literature

Several findings from this study confirm or add to the literature. The following discoveries and how they fit into existing literature will be discussed: recovery, barriers, the impact of SSI on employment, participant ambivalence about work, and their limited knowledge of what supports are needed to become successfully employed. Finally, the

theory that emerged from this study and its findings will be explored in relation to existing literature.

Recovery. Many individuals with MI suffer for years until they find the right medications, coping mechanisms, and supports that help them live productive lives (NAMI, Mental Illness, 2018). The growth of the recovery concept, increasingly effective treatment, and the growing field of psychiatric rehabilitation are making recovery and wellness a reality (NAMI, Mental Health Treatment, 2018; NAMI, Mental Health Medication, 2017; NIMH, Mental Health Medications, 2016).

Two definitions of recovery have been distinguished by Davidson & Roe (2007) in their literature review on recovery, recovery *from* SMI and recovery *in* SMI. Recovery from SMI establishes recovery as a minimization or remission of symptoms and other functional deficits to the extent that they no longer interfere with daily functioning. Recovery in SMI does not require remission of symptoms or other deficits, but views SMI as only one facet of a person's life (Davidson & Roe, 2007). Recovery is not an elimination of symptoms or deficits. It is "...a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential" (SAMHSA, 2008, p.1). This concept of recovery in SMI is reinforced by study participants who are reclaiming the right to a dignified and personally meaningful and satisfying life in the community while continuing to live with SMI. Study participants elucidated how recovery ensued and how it positively impacted their lives. For the study participants recovery began with a commitment to taking medication, learning about their illness, developing coping mechanisms, and accepting support. Recovery made possible things

that seemed elusive for years: a sense of belonging, becoming active in the community, interacting with friends and family, accepting and loving oneself, and hope for employment.

Emerging from this study was the personal and heart felt descriptions of how participants were treated by others in the throes of their illness. Recalling negative experiences with co-workers and employers. They were picked on, talked about, criticized, and fired from jobs. There are ample studies addressing stigma and the impact of stigma on individuals with mental illness but these studies seem sterile compared to the emotions expressed by participants in this study. This current study provides an increased understanding of the continuing emotional impact experienced by study participants due to negative past experiences. This enduring emotional impact contributes to participants' enduring unemployment

Employment as part of recovery. Studies indicate, work contributes to recovery (Bush, Drake, Xie, McHugo, & Haslett, 2009; Dunn et al., 2008; Mechanic et al., 2002). Additionally, it has been shown that work increases self-esteem, provides a valued identity, and improves finances (Dunn et al., 2008; Swarbrick, 2006). The majority of study participants clearly state that they believe work is part of recovery. All participants considered employment was an avenue to increased income enabling them to have and do more. They additionally connected having and doing more with an improved life and enhanced recovery. Paradoxically, participants then elucidated that they could still be in recovery without having a job. Since all participants were unemployed and considered themselves in recovery belief that employment is part of recovery seems contradictory.

This discrepancy in expressed beliefs may be explained later in this chapter under ambivalence.

So many barriers. Multiple empirical studies have identified barriers to employment for individuals with SMI. The majority of these studies are quantitative in nature, which identify and discuss barriers but do not emphasize the deeper implications of these barriers from the individual's perspective. Study participants shared many of the barriers identified in previous studies, adding a deeper emotional understanding of how these barriers impacted their lived experience. The following discussion of barriers are organized in the same format as presented in Chapter four, lacking, supplemental barriers, and internal barriers.

Lacking. Three quarters of all cases of serious MI begin by the age of 24 (NAMI, The numbers count, 2018) disrupting education and early work experiences. The lack of work readiness skills developed in the teens and early twenties combined with low educational attainment and lack of any additional higher-level training are barriers to employment (Barron & Salzer, 2002; Cook, 2006; McAlpine & Warner, 2002; Tschopp et al., 2007). Thus, individuals with MI who have not addressed educational and employment deficits and wish to enter the labor market qualify for only low paid, entry level positions. Limited education, limited or no work history and lack of abilities makes for a poor representation of a job candidate.

All study participants confirmed two or more of the above-mentioned barriers. Only two participants had more than a high school diploma and only one completed enough education to receive a certification. Five participants did not graduate high school. Work history was additionally lacking, with short job tenure and long-term

unemployment for all participants. Some participants discussed their personal belief that they lacked abilities to be employable or believed they would be hired if they applied.

Supplemental barriers. Three characteristics are included in the category supplemental barriers, comorbidity, minority status, and poverty. Only one of these barriers was verbally identified by participants, comorbidity. Seven participants related comorbid conditions that negatively impacted their past employment or was a concern in gaining future employment. Minority status and living under the poverty level were identified through the demographics form, and by the fact that all participants were receiving SSI. Although, not categorized as supplemental barriers comorbidity, minority status, and poverty are all supported by research as barriers to employment (Cook, 2006; McAlpine & Warner, 2002; Tschopp et al., 2007). Internalizing lacking, and supplemental barriers are likely to be contributing factors generating internal barriers.

Internal barriers. Negative past experiences and not believing one can work, because of past experiences, lack of adequate employment history, education, and abilities, were identified by study participants and coded as internal barriers. Corbière, Mercier, and Lesage (2004) recognize an individual's perceptions and self-efficacy can negatively impact employment for individuals with SMI, irrespective of the accuracy of these perceptions. If individuals think they will be worse-off mentally and financially there is diminished motivation to work. Perceived barriers may also interfere with motivation, commitment, and self-efficacy which can directly impact employment outcomes.

SSI's impact on employment. Receiving SSI has been identified as a disincentive to seeking employment for individuals with SMI (McQuilken, et. al., 2003; MacDonald-Wilson, Rogers, Ellison, & Lyass, 2003). Study participants substantiate the literature identifying the fear of losing one's disability payment if becoming employed (Drake, Skinner, Bond & Goldman, 2009; McDonald-Wilson et al., 2003). A few participants did not believe SSI interfered with their becoming employed. Nevertheless, they would seek only part-time work to prevent total loss of their SSI.

One gap this present research fills is the dearth of studies that parse out SSI from SSDI. By including both federal disability programs specific issues that relate only to SSI recipients are either lost or confounded. Each of these programs has different eligibility requirements, potential benefit allowances, and work incentives. Individuals receiving SSI inherently have less work history and fewer assets than individuals receiving SSDI. As stated above, having a poor work history is one of the barriers identified by study participants. A second issue for SSI recipients are the distinct work incentives that differ from SSDI. Individuals receiving SSDI can make up to \$1,180 (SSA, Red Book, 2018) gross per month and continue to receive their full benefit check. While individuals who receive SSI begin to have the SSI benefit amount begin to diminish once they make \$85 gross per month income from a job (SSA, Red Book, 2017). These differences may well make a difference in deciding to work between someone collecting SSI versus SSDI. By parsing out SSI a deeper understanding of the impact of this disability program on employment is garnered. No similar studies examining SSDI alone were found to compare results to this present research.

Not adequately addressed to date is the compounding effect of multiple barriers experienced by study participants. A contribution to the literature is the concept of a composite barrier, a component of the grounded theory emerging from this study. Each of the following: long term mental illness, limited education, work history and abilities, comorbidity, minority status, poverty, internal barriers, negative past experiences, and perceived barriers, were unveiled in all study participants. An amalgam of barriers that may have a weightier influence on employment than any one or two barriers. It is not surprising that being a recipient of SSI and the integration of a composite barrier leads to ambivalence towards employment.

Ambivalence. Song and Ewoldsen (2015) in their article “Metacognitive Model of Ambivalence” constructed a theoretical framework of ambivalence after conducting an extensive literature review of existing studies. Incorporated into this theoretical framework of ambivalence are the concepts of implicit or explicit ambivalence, and the idea that conflicting elements can be evaluated separately under independent conditions. Implicit ambivalence seems to describe participants in this present study. They have a conflict in making an employment decision but are either unaware of their ambivalence or reject one side of their thought process in specific conditions. Depending on the condition participants find themselves, their conflicting thoughts about employment are evaluated separately. One condition may be speaking about beliefs on recovery and employment, while a second condition may be beliefs about SSI and employment. The way interview questions were worded or sequenced may also have impacted participants’ responses. Questions about recovery and employment elicit positive thoughts about

employment, while questions about SSI and employment elicited unfavorable thoughts about employment.

McQuilken et al. (2003) conducted a survey of 389 individuals about their motivation to work and perceived barriers. This article is often cited to substantiate that a large percentage of individuals with SMI who are not working want to work. Of the 310 individuals who were not working 55% reported a desire to work, yet more than half of those who expressed a desire to work were not looking for work. This discrepancy in stating a desire to work, yet not looking may support ambivalence about employment for individuals being surveyed. McQuilken et al. included individuals receiving SSDI along with those receiving SSI. A direct comparison to this present study is not possible, as the present study included only individuals receiving SSI. What is comparable is that even though a larger percentage of individuals expressed the benefits of work most were not looking. Receipt of social security disability benefits contributes to ambivalence and lack of action. Adding to this is the lack of effective support services.

Employment supports. Study participants felt supported by the mental health professional in their recovery and desire to work. Mental health workers provided positive encouragement and basic assistance—as acknowledged by study participants—to support individuals in their expressed desire for employment, yet effective employment services and outcomes were lacking. Professionals who provide mental health services work in a variety of roles and enter the field with varying educational backgrounds and training. Most are not trained to provide employment services or to even grasp the complex skills and knowledge base needed to provide effective employment support services. The most successful employment services for individuals with SMI have been

shown to have high-fidelity to the Individual Placement and Support (IPS) model of supported employment (Hoffmann, Jackel, Glauser, Mueser, & Kupper, 2014; Luciano et al., 2014). Unfortunately, SAMHSA's Uniform Reporting System for State Mental Health Measures (2016) shows that only 2.1% of individuals served by the public mental health system received supported employment services. Education on effective employment services and better coordination of diverse mental health professionals with SE providers is needed.

Not knowing what I don't know or need. One original hope for this study was for participants to voice what changes in the mental health system and social security system would benefit their employment pursuits. Interview questions exploring what participants felt they need, what others need to know and do, and what changes would benefit their becoming employed, were included in this study with the belief that study participants could inform the field of psychiatric rehabilitation and SSA. The findings contradicted this expectation. Very limited and superficial suggestions, if any, were identified by participants. Participants had limited insight into what was needed for them to choose and gain employment. Participants were able to identify some things, such as needing training, resumes, access to applications, and more information, particularly in regards to the impact of employment on SSI. However, they did not have a deep knowledge of what supports would help or were available. I believe this finding means professionals in the field of mental health who specialize in employment need to continue to research and implement effective employment services, and to advocate for increased funding and expansion of employment services for individuals in recovery from mental illness.

Emergent Theory

Several findings from this study have been explored and identified in the literature. What has not been addressed to date is the emergent theory that merges the findings in a way that helps explain enduring unemployment of study participants and can be generalized to similar consortia of individuals. The emergent theory grasps the encumbering reality of a composite barrier established over time that limits an individual's human capital and ability to be competitive in the job market. This theory additionally exposed study participants and mental health professionals limited knowledge of effective employment supports. The composite barrier, which includes receiving SSI, counteracts with the desire to work and the identified benefits of work. This is identified as an obstructing impact of ambivalence. Study participants deal with this ambivalence by not making a conscious decision but having a someday dream of becoming employed.

Researcher Assumptions and Biases

I have worked in the field of psychiatric rehabilitation with a specialty in employment for individuals with mental illness for over 20 years. Admittedly, I had assumptions about the study topic and potential findings. The overwhelming majority of individuals with SMI I assisted in gaining employment received SSI, SSDI, or both. I anticipated that the study participants would have concerns about losing SSI if they became employed; this was supported by the findings. I also anticipated that study participants would perceive part-time employment as more beneficial than full-time. Part-time employment permits SSI recipients a portion of their SSI benefit, which is seen as a safety net. Again, the majority of study participants expressed wanting part-time work.

An additional assumption, and driving force for this study, is that recipients of SSI may have different unique issues that impact their decisions to work, or not, that differ from individuals receiving SSDI. Other driving forces for this study involved additional question I wanted to answer: Why are the majority of individuals in recovery from SMI not seeking employment?

I did believe that more study participants would be actively seeking employment or assistance with finding employment. This was not the case. The four participants who stated they were looking for work spent a limited the time in their pursuit of employment, none of them were asking for or receiving support in their job search.

Two additional assumptions, not supported in this study are, the belief that a life in poverty and the labor market would be seen as barriers to seeking or securing employment. As identified in the literature the impact of poverty is recognized as one of the barriers to employment. Although, all participants identified the need for additional income to improve their economic status, no participants identified their life in poverty as an impediment to finding employment. This does not counter the literature but was not seen as a key deterrent within the study participants perception. Interestingly, none of the study participants identified the economy or labor market as a barrier to their seeking or securing employment. An unfavorable labor market negatively affects many working age adults but seems to have a larger impact on individuals with MI (Baron & Saltzer, 2002; Cook, 2006; McDonald-Wilson et al., 2003; Trupin, Sebesta, Yelin, & LaPlante, 1997). The improving economic and labor market status may be a reason for participants not identifying the economy as a barrier.

I additionally assumed that because study participants identified as being in recovery that the professionals providing mental health and recovery services would be offering more advanced employment support, or referring their clients to a supported employment program that specializes in services for individuals with MI. As recovery becomes a reality for more individuals with MI, and research shows employment as recovery tool, my bias is towards mental health professional working more assertively to assist clients with preparing for and pursuing employment.

Limitations

There were several limitations to this study. First, all participants were involved in public mental health services in their community—day program, supported housing and self-help. The individuals attending a self-help program were additionally receiving mental health care at another location. Study findings may not transfer to individuals receiving treatment from a private source. The age and length of stay in the public mental health system of study participants also posed limits. Although findings express the lived experience of individuals with long-term mental illness, these findings may not be the same for individuals who achieve recovery at an earlier age.

Gender and ethnicity were not evenly distributed. Two-thirds of the study participants were female. Whether this biases data interpretation is not evident but needs to be considered. Ethnicity was heavily skewed toward minority status. Fourteen participants identified African American, Native American, or Hispanic, one participant classified himself as other. In the fourth quarter of 2017, unemployment rates for the general population of whites was 3.1%, African Americans/Blacks was 6.4%, and Hispanics/Latino was 4.3%, showing a higher unemployment rate for minority

individuals (BLS, 2018). When ethnicity and gender were parsed out, minority women had lower unemployment rates than men. White men had an unemployment rate of 3.2%, black men 7.0%, and Hispanic men 3.8%. White women's unemployment rate was 3.0%, black women 5.9%, and Hispanic women 4.8%. Even though minority women had a lower unemployment rate than their male counterparts, minorities overall have a higher unemployment rate than whites, both male and female. An interesting question is, does the higher unemployment rate for minorities in the general population hold for individuals with SMI?

Although member checks are frequently used to clarify or confirm study findings it was not used in this study. Thomas (2016) questions the effectiveness or necessity of member checks, specifically in research aimed at theory development, supporting my choice not to conduct member checks. Strict adherence to transcript accuracy was followed to assure accurate participant responses. Quote used throughout this document are verbatim and assist the reader in affirming findings as presented.

Follow Up and Modifications

Reflection and evaluation of this study has highlighted what is needed to follow up now that the study has been completed, what I would have done differently, as well what worked well and I would not change. My follow up plan includes several things. First, I will be providing a summary report to the agencies who assisted me with recruiting study participants. They were supportive in my efforts and interested in the outcome. Second, I will write at least one article on the results and submit it to be published in a peer reviewed journal. Third, I will continue to explore SSA's data base on SSI to see if there is any additional supporting or divergent data in regards to

employment of SSI recipients. Forth, I will look for SSA's grant opportunities that may provide a larger scale study on SSI.

A modification to future studies would be formally, incorporating Critical Disability theory as an additional framework. I would additionally start writing memos earlier in the process. I delayed writing memos until after I met with the majority of the study participants. This is not appropriate protocol for grounded theory research. By not writing memos early and often, data analysis became more cumbersome than I would expect if I had not delayed this vital grounded theory process. I would additionally use more action oriented initial codes. I did struggle with initial coding and learning NVivo concurrently. I went through three iterations of initial coding before I felt comfortable with my codes and what they meant. I found NVivo less than user friendly and my last attempt at initial coding was in an excel spread sheet. I realize this was all part of my learning process and was glad to preserve till I achieved more meaningful codes. NVivo ended up being of great help once I overcame this initial barrier. I plan to continue to learn additional aspects of NVivo to benefit my future research as I realize I have grasped only the basics of NVivo.

Implications of the Theoretical Framework

The overarching theoretical framework for this study is constructivism. This framework supports the qualitative research belief of exploring the lived experience and beliefs of the study participants. Additionally, Critical Disability theory had implicit implications for this study.

Constructivism. The theoretical framework for this study employed Charmaz's (2006) constructivist view of grounded theory. Constructivist theory is interpretive, looking to understand the studied phenomenon and "assumes emergent, multiple realities" (p. 126). As a researcher I aimed to interpret the participants' meanings and actions as closely as possible, knowing I cannot fully replicate their lived experience. The emergent theory developed from the study findings is interpretive and is not independent of my views and experience.

Critical Disability Theory. Although not originally identified as a supporting theoretical framework, Critical Disability Theory (CDT) has a strong significance in this study. One of my original aims was to utilize findings that will positively effect services and policy impacting individuals with MI. I anticipated findings with the potential to influence policy makers at the state and federal level within both the Division of Mental Health and the Social Security Administration. It is hoped that the answers to several questions introduced in this chapter are answered, at least in part by this study's findings: Are mental health professionals aware of what programs will best serve individuals on SSI? Are policy makers aware of what changes in policies will best assist in improving employment outcomes? Constructivist theory in conjunction with CDT have implications for policy makers, including the consequences of policies on the individuals represented in this study.

Achieving Research Aims

This study contributes to a greater understanding of the lived experiences of the study participants and the interrelated factors that lead to their enduring unemployment. Viewing the data through the lens of critical disability theory mental health professionals,

the mental health system, and policy makers can gain better insight into what will best serve individuals in recovery from MI who receive SSI. By viewing data through an analytical lens, a substantive theory was developed and represented by a written and visual framework. This theory not only helps to describe the process that leads to enduring unemployment, it provides information in a new light with the potential to advance strategies and policies that will lessen the burden of unemployment for individuals with MI.

Implications of Findings

Findings from this study have implications for the field of psychiatric rehabilitation and policy makers. The following sections will address implications of this current study.

Implications for the field of mental health. Individuals served within the field of mental health have the most to gain from the findings of this study. Study findings provide the mental health field with a clearer understanding of the influences that lead to enduring unemployment of individuals in recovery from SMI. This increased awareness has the potential for improving services to better enable individuals in seeking and gaining employment.

Comprehending the overall complexity and interlacing of obstacles faced by individuals in recovery from SMI who receive SSI is expected to have the greatest impact on the field of rehabilitation. Addressing enduring unemployment for individuals with similar lived experiences as this study's participants will not be a simple fix. The composite barrier and the obstructing impact of ambivalence needs to be addressed as a whole when assisting someone in seeking employment.

IPS supported employment. Evidence based IPS supported employment (SE) programs have been shown to be the most effective employment service for individuals with MI. Yet employment outcomes are still low. Twenty-four randomized control trials studying the competitive employment outcomes of IPS programs indicate a median competitive employment rate of 55% (IPS Employment Center, Evidence for IPS, 2018). IPS Employment Center's Learning Community houses the largest data base of competitive employment outcomes for the IPS. The Learning Community is a cohort of 215 agencies from 23 states providing IPS services. Employment outcomes are compiled each quarter. In 2017, 4th quarter numbers showed 17,755 individuals being served and an average employment rate of 44%. Even though IPS is shown to be the most effective service to assist individuals with MI to become competitively employed, outcomes leave a vast area to be improved. Parsing out individuals who receive SSI from SSDI may provide additional insight into reasons for low employment rates.

Providing resumes, assisting with job search skills, or supporting someone in gaining a higher educational level may all be needed but are not enough for individuals to overcome the complexity of their lived experience. Individuals receiving SSI may need different strategies or services than those receiving SSDI. Individuals on SSDI have a more substantial work history, may not have the same lived experiences as this study's participants, and are not affected by the same SSA work incentives.

The Executive Director of NAMI national, Mary Giliberti states, "Work is a critical part of recovery. As a nation, we still have a long way to go in recognizing that linkage" (NAMI, 2014b, p.1). A thoughtful and comprehensive exploration of strategies and services is needed to assure a positive impact on employment outcomes for

individuals with SMI. Mental health professionals—at both the ground and organizational level—researchers, and funders must all be participants in this exploration.

Implications for state and federal government. Policy makers in the federal and state governments are in the position to have the greatest impact on improving employment outcomes for individuals in recovery from SMI who receive SSI with changes in the laws, regulations, and funding allocation. This study has the greatest implications for the Social Security Administration (SSA).

Implications for SSA. The SSA disability system, which provides sustenance in time of need also perpetuates long-term dependency (Baron & Saltzer, 2002; McDonald-Wilson et al., 2003). Acceptance of U.S. policies that tolerates poverty, and provide limited opportunities to escape from poverty, need to change. As revealed in this study individuals with SMI who receive SSI benefits have concerns over the loss or reduction of benefits.

Ticket to Work and Work Incentive Improvement Act (TWWIIA) of 1999 (SSA, 1999) eased some of the disincentives in returning to work for individuals on SSI. Yet, work-disincentives inherent in the SSA system remain. Notable concerns are a sluggish bureaucratic system that affects reinstatement of cash benefits if a person becomes ill again. Delays in coordinating adjustment of SSI benefits with monthly income from employment commonly initiates overpayments or underpayments. Both overpayments and underpayments further complicate a beneficiaries monthly financial security. There is additionally a steep decline of food stamps allotment and housing subsidy once a person begins receiving earned income (Halloran, 1991; McDonald-Wilson et al., 2003), as these are based on total monthly income. The present SSI work incentives provides for

a larger gross income for anyone working. Then taxes on earned wages, the decline in food stamp allotment, and decrease in housing subsidy makes the increased income from employment less advantageous.

Although TWWIA 1999 legislation addresses some of the work barriers for SSI recipients, barriers still remain. In 2005, a report published by the National Council on Disability supports new approaches to support employment for SSI and SSDI beneficiaries. “Complex obstacles to employment faced by SSA beneficiaries requires a comprehensive set of solutions.” (National Council on Disability, 2005, p. 1). Policy makers, mental health professionals, and those impacted by SSA legislation need to come together and thoughtfully explore advancing SSI work incentives to most effectively support employment for beneficiaries.

Personal implications. As an educator and researcher this study has expanded my knowledge of the encumbering unemployment of individuals in recovery from SMI. Information gleaned from this study will be used in educating mental health professionals in the classroom and in conference presentation. I have also been stimulated by areas of continued research, which will further expand on these findings.

Implications for future research. One area of interest is studying how Information Processing Theory (CIP) (Sharf, 2013; Zunker, 2016) and other cognitive strategies in conjunction with SE may increase employment outcomes. One area that traditional SE services do not address is the ambivalence of job seekers receiving SSI. Involvement in a public mental health system and being a social security beneficiary, are not sufficiently addressed by general career and vocational theories. A theory that incorporates these factors, expressed from the perspective of the individuals in recovery

may be useful to understanding the unique employment decision making process of individuals in recovery from MI. One career theory that may contribute to improving employment outcomes for individuals with MI receiving SSI is Cognitive Information Processing Theory (CIP). Goal clarification, countering a troubling belief, addressing inconsistencies between words and actions and cognitive rehearsal. This study identified inconsistencies between words and actions for study participants. Believing they are in recovery, that employment is part of recovery, that employment contributes to a better life style and their recovery would seemingly lead to seeking and securing employment. Eleven of the 15 participants admittedly were not looking for employment, and those that were looking were taking meager steps.

A mixed method studies exploring the use of CIP techniques with individuals in recovery from MI receiving SSI would explore CIPs benefits for this cohort of individuals. Research questions could explore changes in participants beliefs and actions and the impact on employment outcomes. Pre and post exploration of participant could explore participant's thoughts and ambivalence towards employment. Does incorporating CIP in traditional SE service change cognition in individuals in recovery from MI and who are receiving SSI? Does incorporating CIP in traditional SE service change action in individuals in recovery from MI and who are receiving SSI? Does incorporating CIP in traditional SE services improve employment outcomes?

One future study of interest is exploring the benefits of merging the career development theory Cognitive Information-Processing (CIP) into SE or other pre-employment groups provided at mental health agencies. This integration of CIP into other employment related services would specifically attend to an individual's belief system

around employment, career decision making, and provide effective strategies for effective decision making and problem solving. This approach of integrating theory and practice may address ambivalence and lack of action in individuals recovering from mental illness. A quantitative or mixed method study would be proposed with random assignments to either a control or experimental group. An overarching research question would be “does integrating CIP into SE or other employment related services positively impact employment outcomes for individuals recovering from MI?”. Two hypotheses are proposed, 1. “does integrating CIP into SE services impact ambivalence toward employment for individuals in recovery from MI,” and 2. “does integrating CIP into SE services improve employment outcomes for individuals in recovery from MI?”.

A second study of interest is further exploration of the impact of receiving SSI on employment ambivalence and outcomes for individuals in recovery from MI. Although several SSI work incentives have made it more palatable for individuals receiving this benefit, these incentives are obviously not enough to overcome the complexities of working and receiving SSI. If someone is still on the SSI rolls and works at a job with varying hours and monthly income, this income must be tracked and reported to SSA so adjustments to SSI check can be made. This becomes cumbersome to track. In a month someone receives a larger paycheck a decrease in the amount of a SSI check is triggered; this does not take place simultaneously. SSA lags in its review and adjustment of SSI checks potentially leaving someone receiving a smaller SSI check in the same month a paycheck is less. This system perpetuates over or underpayments to SSI recipients, both with tragic consequences, having to pay back SSA or being left without enough money to live on in any one month. Additionally, an increase in monthly income from work

decreased a person's food stamp allotment. Along with this, anyone who receives a housing subsidy will now have to pay a higher portion of rent. Admittedly, changes in any of the work incentives or subsidies would be out of my control. What I would seek to do is submit a grant proposal to SSA suggesting a pilot study exploring employment outcomes for individuals receiving SSI if work incentives were less cumbersome and more favorable to beneficiaries when they become employed.

Conclusion

The motivation for this study began with a desire to understand why individuals in recovery from SMI remained unemployed. As a professional in the field of psychiatric rehabilitation I observed individuals who were involved in their communities, volunteered, actively served on mental health boards, and offered recovery support to other individuals with SMI. Their days were full and active. Why were they not seeking or gaining employment?

This grounded theory study was conducted to gain insight and understanding into the enduring unemployment of individuals in recovery from SMI, who were receiving SSI benefits. Empirical studies discussing the impact of disability benefits on employment include both recipients of SSI and SSDI in one study. It is expected that employment decision making for SSI recipients may differ from employment decision making of SSDI recipients. This current study parses out individuals who receive only SSI benefits. It sets the ground work to understand the unique experiences of individuals with SMI who receive SSI benefits. By gaining knowledge about study participants unique experiences targeted strategies can be developed to aid them in employment decision making.

A grounded theory approach was selected for the purpose of constructing a theory to explain enduring unemployment of individuals in recovery from SMI who receive SSI benefits. Fifteen study participants were interviewed about their recovery, employment, SSI, and what additional support would assist them in becoming employed. Interview transcripts were coded and analyzed using grounded theory methods as posited by Charmaz (2006, 2014).

Four theoretical concepts emerged that supported the development of theory: composite barrier, encumbering reality, obstructing impact of ambivalence, and someday dream of inaction. These concepts and emergent theory add new or expanded understanding of the encumbering unemployment of these study participants. Findings accentuates the complexity and amalgamating of experiences. More than simple solutions are needed to address the intertwined barriers sustaining unemployment for individuals in recovery from SMI who receive SSI.

It is hoped that this study will be used to help other individuals with the same criteria as the study participants. To be of help, professionals in the field of mental health, policy makers, and particularly the Social Security Administration must understand the implications of this study that changes in strategies, services, and policy must be changed to address the complex and intertwined issues that impact individuals in recovery from SMI who are receiving SSI benefits.

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Appendix A

Permission to be Contacted for Research Study

As part of the dissertation process Francine M. Bates, a doctoral candidate attending Rowan University's Educational Leadership Program, is conducting a study to explore the employment decision making process of individuals in recovery from mental illness who are receiving or have received supplemental security income (SSI).

This is a study may provide valuable information that will aid in alleviating some of the problems that contribute to this high unemployment rate.

As a person who meets the criteria you are eligible to become a participant in this study.

- Criteria:** Is between 25 and 54 years of age
Person is in recovery from a mental illness
Person is receiving SSI
Not hospitalized for mental illness for at least one year
Living independently in the community for at least one year

In order for you to learn about the study, and to determine whether you want to participate, we are asking your permission to give Francine your contact information. Therefore, may I have your permission to give your name, home telephone number, address, e-mail/or other contact information to Francine who will contact you to set up an appointment to discuss the study?

Giving permission does *not* mean you're agreeing to do the study just that you're willing to speak with Francine to learn more about the study.

Any conversation and or information that you share with the research staff will not be shared with us. You have the right to refuse to be contacted. If you do agree to be contacted by Francine it is voluntary.

I agree to being contacted. I would like to learn more about the research.

My contact information is:

Home telephone # _____ Cell #: _____

E-mail address: _____ Other: _____

Home address:

I do not want to be contacted. I am not interested in participating in any research.

Appendix B

Advertisement Flyer

**IF YOU ARE AN INDIVIDUAL IN RECOVERY FROM
A MENTAL ILLNESS
&
ARE UNEMPLOYED
YOU MAY BE ELIGIBLE**

INDIVIDUALS FROM AGES 25-54 ARE INVITED TO PARTICIPATE IN A STUDY
EXPLORING FACTORS THAT AFFECT EMPLOYMENT.

MENTAL HEALTH DIAGNOSIS INCLUDE DEPRESSION, ANXIETY, BIPOLAR,
SCHIZOPHRENIA OR SCHIZO-AFFECTIVE DISORDER.

TIME COMMITMENT TO THE STUDY IS 1 TO 2 HOURS.

FOR MORE INFORMATION, PLEASE CALL:

1-856-566-2771

OR

1-609-204-2942

YOUR PARTICIPATION WILL BE CONFIDENTIAL

RECOVERY AND EMPLOYMENT STUDY (609) 204-2942	RECOVERY AND EMPLOYMENT STUDY (609) 204-2942	RECOVERY AND EMPLOYMENT STUDY (609) 204-2942	RECOVERY AND EMPLOYMENT STUDY (609) 204-2942	RECOVERY AND EMPLOYMENT STUDY (609) 204-2942	RECOVERY AND EMPLOYMENT STUDY (609) 204-2942	RECOVERY AND EMPLOYMENT STUDY (609) 204-2942
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Appendix C

Informed Consent

Mental Illness, Employment, and Recovery

I agree to participate in a study entitled "Employment Decision Making of Individuals in Recovery from Mental Illness," which is being conducted by Francine Bates, a doctoral student of the Department of Educational Leadership, Rowan University. My agreement to participate is voluntary.

The purpose of the study is to gain a deeper understanding of the factors that influence a person in recovery from mental illness to make decisions about employment. I will be using the data I collect to complete my doctoral dissertation and will submit articles for publication in research journals.

I understand that I will be asked questions about my recovery, employment, opinions about what I believe influence my decisions about employment. This will take about one to two hours of your time. I also understand that the study investigator may contact me again to ask further questions to help her better understand the information she is gathering. If I am contacted again it will be within two months of this first interview and will take less than one hour of my time.

I understand that my responses will be confidential. My name and identity will not be disclosed at any time and any written or recorded data will be identified by a code number known only to the investigator. I agree that any information obtained from this study may be used in any way thought best for publication or education provided that I am in no way identified and my name is not used.

I understand that this interview will be audiotaped with my permission.

I understand that there are no physical or psychological risks involved in this study, and that I am free to withdraw my participation at any time without penalty.

I understand that my participation does not imply employment with the state of New Jersey, Rowan University, the principal investigator, or any other project facilitator.

I understand that I will receive a \$10.00 gift card for my time once I complete the interview questions. If I am contacted a second time and agree to meet face to face with the investigator I understand I will receive an additional \$10.00 gift card for my time.

Participant's Initials _____

If you have any questions about your rights as a research subject, you may contact the Associate Provost for Research at:

Rowan University Institutional Review Board for the Protection of Human Subjects
Office of Research
201 Mullica Hill Road
Glassboro, NJ 08028-1701
Tel: 856-256-5150

If I have any questions or problems concerning my participation in this study, I may contact Francine Bates at 609-464-4664 or fbates30@comcast.net

Or I may contact her study chair, Dr. Boles-Williams at 856-256-4500 x3804 or williamsb@rowan.edu

I have read and understand this consent form. All my questions have been fully answered and I volunteer to participate in this research study. I understand that I will receive a copy of this form.

Participant name (print): _____

Participant signature: _____ Date: _____

I understand that the interview will be audiotaped and I agree to participate while being recorded.

Print name

(Signature of Participant) (Date)

(Signature of Investigator) (Date)

Signature of Investigator or Interviewer:

To the best of my ability, I have explained and discussed the full contents of the study, including all of the information contained in this consent form. All questions of the research participant have been accurately answered.

PI or interviewer (print name): _____

Signature: _____ Date: _____

Appendix D

Demographics Intake Questionnaire

(Circle or fill in the correct response)

1. Participant ID# _____
2. Location Demographic information taken _____
3. Date since last psychiatric hospitalization _____
4. Date of Completion _____
5. Gender: 1. Male 2. Female
6. Date of Birth: ____/____/____
7. Age at time of interview: _____
8. Race/Ethnicity: 1. Caucasian 2. Hispanic 3. African-American 4. Asian
5. Other
9. Highest grade completed: _____ (e.g., 10th grade = 10 sophomore year;
Associates = 14)
10. Current employment status: 1. Unemployed 2. Volunteer job 3. Sheltered
4. Part-time 5. Full-time 6. Other _____
11. Time since last competitive job: _____ (in months)
(e.g., 5 years = 60; 0 = currently employed; 998 = never had a job)
12. Longest held competitive job _____ (in months)

Additional entitlements currently receiving:

13. SSI 1. Yes 2. No Amount _____
14. SSDI 1. Yes 2. No Amount _____
15. VA Benefits 1. Yes 2. No Amount _____
16. Food Stamps 1. Yes 2. No Amount _____
17. Other 1. Yes 2. No Amount _____
18. Marital Status: 1. Never married 2. Married/Living with Partner
3. Separated 4. Divorced 5. Widowed
19. Psychiatric Diagnosis _____

Appendix E

Participant Recovery Scale (PRS)

Participant ID# _____ Date _____ Location _____

On a scale of 1-5 describe your view of recovery. Five being full recovery and one the least recovered. Write a description of each phase along this scale. Start with one and five, then fill in intermediate levels.

5 Highest Recovery _____

4 _____

3 _____

2 _____

1 Not in Recovery _____

Appendix F

Interview Questionnaire

Participant ID# _____ Date _____ Location _____

Thank you for meeting with me today. Like we discussed during the informed consent I will be tape recording this interview so I do not miss anything. I will also be taking notes. I will be asking you a number of questions about recovery and employment. There is no right or wrong answers; this interview is about you, and what you think.

A couple of clarifications, if I use the word illness or recovery, I am only referring to mental illness and recovery from mental illness, not other illnesses. When I talk about employment I am referring only to paid employment.

Are there any questions before we begin?

1. Tell me what it is like to be in recovery from mental illness? What does recovery from mental illness mean to you?

2. In your opinion is paid employed part of recovering from mental illness?
 - a. If so, explain how.
 - b. If not, explain.

3. Tell me about your thoughts and feelings about paid employed?

4. Did you have an employment goal prior to becoming ill? If so, what was it? Is it still your goal? Why or why not?

Participant ID# _____ Date _____ Location _____

5. Tell me about your work prior to your diagnosis of mental illness? After your diagnosis of mental illness?

6. Have you been looking for employment since you became ill? If so, are you still? What is your reasoning?

7. Do you see paid employment as a possibility for you now or in the future? Full-time? Part-time?
 - a. If so, how will this happen?
 - b. If not, what will keep you from becoming employed?

8. Do you feel like you are able to make a decision to get paid employment? Did you make this decision? Tell me how you made the decision to work or not? Did others make this decision for you? If so, who?

9. What services are available/lacking that would lead you to look for paid employment?

10. If you look for employment do you believe you would get employed? Explain.

Participant ID# _____ Date _____ Location _____

11. In your opinion does SSI/DI prevent you from seeking paid employment? If so, how?

12. What is the most important thing that would help you seek and gain employment?

13. Do you believe it is possible for you to gain employment that would pay enough to get off of SSI/DI, be self-supporting?

14. What ideas or understanding do mental health providers need to know to make paid employment a possibility for you?

15. What ideas or understanding does the Social Security Administration need to know to make paid employment a possibility for you?

16. What is the most important thing you talked about today, or haven't yet mentioned, that prevents you from seeking or gaining paid employment?

Thank you for taking the time to meet with me.

Appendix G

Initial Codes

NVivo Initial codes			
	Codes	# Sources	# References
1.	I want a second income for myself besides SSI	1	1
2.	Ambivalence	5	16
3.	Associates symptoms with working full time in the past	1	1
4.	Barriers to fulltime employment	10	18
5.	Believing full time work is possible	5	5
6.	Believing part time work is possible	6	9
7.	Benefits of employment	9	13
8.	But not doing it	1	1
9.	Comorbidity	5	10
10.	Deciding	1	1
11.	Discouraged from competitive work by others	4	9
12.	Discrepancy	2	5
13.	Does not believe work is possible at this time	6	6
14.	Does not feel stuck on SSI	2	2
15.	Doesn't have the needed skills or education to get employed	1	1
16.	Employment as part of recovery	7	13
17.	Employment is not primary goal in life	3	3
18.	Encouraged to become employed	1	1
19.	Fear of rejection	1	1
20.	Full time	1	1
21.	Full time work would put too much pressure on me	1	1
22.	Getting off SSI	6	7
23.	Goals	1	2
24.	Has a payee	1	1
25.	Information	7	17
26.	information as part of recovery	1	1
27.	Internal barriers to employment, thoughts and beliefs	4	6
28.	Internal fears	3	7
29.	Interview inspired thoughts about employment	3	3
30.	Is there follow through with support team	2	2
31.	It's out of my control, passive	3	4
32.	Looking	2	3
33.	Lost years	5	8

34.	Maintaining employment	1	1
35.	Maybe part-time, not full-time	4	4
36.	Not wanting to lose SSI	1	1
37.	Most important thing right now	1	1
38.	My present focus-wellness	1	1
39.	Needs more information about impact of employment on SSI and or health insurance	3	5
40.	Needs training to reach employment goal	4	5
41.	No plans to achieve work goal	2	2
42.	Not believing can make enough money to get off SSI	4	5
43.	Not looking for work since diagnosed	5	13
44.	Not wanting to be stuck on SSI	2	2
45.	Not wanting to lose SSI	3	6
46.	Paid employment	5	10
47.	Paid employment and recovery	6	9
48.	Part-time employment. I could go out and do things and have more money. Like go on trips.	3	5
49.	Passage of time	Demographics	
50.	Past problem with SSA	1	2
51.	Past work history	2	2
52.	Present needs, information, help and education	2	3
53.	Present work goal, to work in a factory on an assembly line	1	1
54.	Receiving help vs not receiving help	12	41
55.	Needing help but not asking for help	1	2
56.	Recovery	13	53
57.	Job	6	6
58.	Safety at wellness center	1	1
59.	Short term job tenure	3	3
60.	So why isn't she working	1	1
61.	SSA needs to know	10	14
62.	SSI and paid employment	10	24
63.	SSI and unemployment	1	1
64.	SSI as a stepping stone	3	3
65.	SSI enough money to meet my needs, but nothing more	2	2
66.	SSI is not enough	2	5
67.	Support as part of recovery	1	1
68.	Symptoms	6	9
69.	The other side of recovery	7	15
70.	The past and missed employment opportunities	8	36

71.	Thinking about work	4	5
72.	Unsure	1	2
73.	Unsure where these fit if anywhere	2	2
74.	Valuing employment	1	2
75.	Vision of work off in the future	9	17
76.	What case managers need to know	9	15
77.	What I need to do to become employed	7	19
78.	What prevents her from working	2	2

Follows examples of in-vivo statements included in above identified initial codes:

Ambivalence

I guess just not being clear on a plan.

Procrastination.

I guess part is doubting myself, not having a 100% like I can do this, I can do this. I don't know.

One of the CPSs mentioned that she had applications about the training but I just didn't follow through with it, not yet.

It's just not time yet for the doors to open up for me to receive that blessing.

No I haven't. [made the decision to work]

[I'm] Resting.

I just need some time.

I'm resting right now but once I make up my mind, I'll go forward and get a job.

Motivation.

I don't know. I'm uncertain about getting a job right now.

Would they hire me, would they take me knowing my background and everything?

No, I'm not 100 percent decided.

So-so. In between.

Yes. I received a ticket to work. But I never did look for a job.

Haven't been on any interviews or filled out applications, not yet.

The initial Ambivalence code was later merged with other similar [But not doing it, It's out of my control, passive, Deciding, Discrepancy, Unsure, Thinking about work, Not looking for work since diagnosed] codes to form the composite code: Ambivalence

Benefits of Employment

If I was to have a job it would be to do things that I haven't been able to do

To have more money, clothe myself, feed myself, pay my bills, go places with my friends.

To have a little extra cash.

It would make me feel better. It would make me be motivated.

I wouldn't have to worry about being late on my rent.

Have enough money to pay my own bills, if I wanted to get married and have a family.

Have enough money for hobbies, like fishing or boating.

Just to get extra money. I ain't gonna lie. Just extra money.

Yes, the extra money.

I could go out and do things and have more money. Like go on trips.

More money to do things with

It's about getting a check.

Having an income makes work important.

Appendix H

Focused Codes

First iteration of focused codes

Recovery

- Recovery- Process and Outcome
 - Doing things differently
 - Seeing the difference
 - The other side of recovery
- Employment as part of recovery
 - Paid employment and recovery

Valuing employment

- Benefits of employment
- I want a second income for myself besides SSI
- SSI enough money to meet my needs, but nothing more
- SSI is not enough

Barriers to Employment

Multiple

- Barriers to fulltime employment
- Comorbidity
- Doesn't have the needed skills or education to get employed
- Lost years
- Needs training to reach employment goal
- Past problem with SSA
- Past work history
- Short term job tenure
- Symptoms
- The past and missed employment opportunities

Internal

- Associates symptoms with working full time in the past
- Fear of rejection
- Internal barriers to employment, thoughts and beliefs
- Internal fears
- Maintaining employment
- Safety at wellness center

SSI and paid employment

Impact on Employment

Does not feel stuck on SSI
Getting off SSI
Not believing can make enough money to get off SSI
Not wanting to be stuck on SSI
Not wanting to lose SSI
SSI and paid employment
SSI and unemployment
SSI as a stepping stone

Full-time vs part-time

Believing full time work is possible
Believing part time work is possible
Paid employment
Does not believe work is possible at this time
Full time
Full time work would put too much pressure on me
Maybe part-time, not full-time
Not wanting to lose SSI

Ambivalence

Ambivalence
But not doing it
Deciding
Discrepancy
Employment is not primary goal in life
It's out of my control, passive,
No plans to achieve work goal
Not looking for work since diagnosed
Thinking about work
Unsure
Unsure where these fit if anywhere
Vision of work off in the future

SupportEmployment Support Positive and negative

Discouraged from competitive work by others

Encouraged to become employed

Is there follow through with support team

Needing help but not asking for help

Receiving help vs not receiving help

What participants believe they need to become employed

Information

Help

Education/training

Not knowing what I don't know

Looking (unsuccessfully)

What I need to do to become employed (it's what I know)

Feeling supported, but is it enough

What participants think others need to know

SSA needs to know

Case managers need to know

Interview inspired thoughts about employment

Appendix I

Focused Codes Answering Research Questions

Overarching Research question:

What leads to the enduring unemployment of individuals in recovery from mental illness who are receiving SSI?

Answered by theoretical concepts and developed theory

RQ 1. What is the process that leads to continued unemployment of individuals in recovery from mental illness?

Composite Barrier

Ambivalence

Ambivalence

But not doing it

Deciding

Discrepancy

Employment is not primary goal in life

It's out of my control, passive,

No plans to achieve work goal

Not looking for work since diagnosed

Thinking about work

Unsure

Unsure where these fit if anywhere

Vision of work off in the future

Employment Support Positive and negative

Discouraged from competitive work by others

Encouraged to become employed

Is there follow through with support team

Needing help but not asking for help

Receiving help vs not receiving help

RQ 2. What factors identified by individuals in recovery from mental illness contribute to their unemployment?

Barriers to Employment

Multiple

Barriers to fulltime employment

Comorbidity

Doesn't have the needed skills or education to get employed

Lost years

Needs training to reach employment goal

Past problem with SSA

Past work history

Short term job tenure

Symptoms

The past and missed employment opportunities

Internal

Associates symptoms with working full time in the past

Fear of rejection

Internal barriers to employment, thoughts and beliefs

Internal fears

Maintaining employment

Safety at wellness center

RQ 3. How does paid employment fit into the definition of recovery for individuals in recovery from mental illness?

Recovery

Employment as part of recovery

Goals

Job

Information as part of recovery

Paid employment and recovery

Recovery- Process and Outcome

Support as part of recovery

The other side of recovery

Valuing employment

Benefits of employment

I want a second income for myself besides SSI

Part-time employment. I could go out and do things and have more money

SSI enough money to meet my needs, but nothing more

SSI is not enough

RQ 4. How do individuals in recovery from mental illness make the decision to work, or remain unemployed?

Ambivalence

SSI and paid employment

Impact on Employment

Does not feel stuck on SSI

Getting off SSI

Not believing can make enough money to get off SSI

Not wanting to be stuck on SSI

Not wanting to lose SSI

SSI and paid employment

SSI and unemployment

SSI as a stepping stone

Full-time vs part-time

Believing full time work is possible

Believing part time work is possible

Paid employment

Does not believe work is possible at this time

Full time

Full time work would put too much pressure on me

Maybe part-time, not full-time

Not wanting to lose SSI

Not consciously deciding

RQ 5. From the perspective of individuals in recovery from mental illness, what needs to happen for them to choose employment?

What participants believe they need to become employed

Information

Needs more information about impact of employment on SSI and or health insurance

Present needs, information, help and education

What participants think others need to know

SSA needs to know

What case managers need to know

Not knowing what they don't know

Looking (not successfully)

What I need to do to become employed

Feeling supported, but is it enough?
