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Work activity in the process of recovery – an interpretive phenomenological analysis of the experiences of people with a schizophrenia spectrum diagnosis

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Summary

Introduction. Having the opportunity to work has been found meaningful for individuals suffering from severe mental illness, in order to boost their self-esteem, provide a sense of control over their lives and of belonging to a community. There are no studies in Polish literature on the process of recovery from schizophrenia with reference to work activity.

Aim. The objective of this research was to explore personal experiences of people employed in Vocational Development Centers.

Methods. Eight semi-structured interviews were conducted with adult patients. Their transcripts were subject to interpretative phenomenological analysis (IPA).

Results. Having the opportunity to work was significant for participants because it mobilized them and encouraged self-care. Going to work helped them overcome social isolation by meeting people with similar difficulties and those who did not suffer from mental illness. Financial gratification enables a sense of independence and the ability to develop skills to plan and control their budget.

Conclusions. This study finds that patients who lost their jobs due to mental illness should be encouraged to utilize rehabilitation institutions to help them undertake work activity and use previously acquired qualifications or develop new skills. Access to appropriate psychological support should be provided during vocation reorientation and adaptation into new work environments. This helps patients regain a sense of control and purpose, and cope with losing valued social roles. We also highlight the need for further studies into challenges in the workplace and the strategies patients use to cope with them.

Key words: work activity, schizophrenia, interpretive phenomenological analysis (IPA)

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Professional activity among people with severe mental illness

Being out of work, especially in the case of long-term unemployment, can have an adverse effect on both physical and mental health. A meta-analysis conducted by Murphy and Athanasou [1] shows that losing one's job is extremely stressful and leads to health deterioration. Unemployment can trigger depression, anxiety, and psychosomatic disorders and has a negative impact on quality of life and self-esteem [2, 3]. Negt [4] refers to research conducted in the 1930s by Lazarsfeld and Jahoda on the effects of unemployment, who found that individuals who have lost their jobs often experience losing a sense of reality associated with the lack of a regular workplace. This is because workspace is often a reference point to time and space. It is also a source of identity and provides a valued social role as an employee [4, 5]. Kaszyński [6] finds that employment enables individuals to participate in social life. People with disabilities, especially those suffering from mental illness, face specific difficulties relating to work activity: they are more susceptible to losing jobs due to health difficulties and they find it much more difficult to return to work [7–10]. Unemployment can lead to deepening of existing mental disorders [11] and is seen as a barrier to recovery [12].

Work is a complex form of activity and a key element of the rehabilitation process [13]. Work activity and other structured forms of active participation in social life are regarded as significant factors in improving mental health in people with severe psychiatric illness [14, 15]. Despite that, the employment rate among people with severe mental illness in Western Europe and Northern America is barely 10–20% [6]. In the group of people with disability associated with mental disorders, 37% have never undertaken any career [16]. Only about 2% of those diagnosed with schizophrenia have a full time job [5].

In Poland, there is no comprehensive, integrated, rehabilitation system referring to employment issues and most people with severe mental disorders never use psychiatric rehabilitation [17]. Moreover, employment is rarely perceived as a significant goal in the treatment of mental illnesses, despite evidence of its significant therapeutic effect [18]. For this reason, the National Mental Health Program in Poland stresses the importance of returning to full-time work and improving access to vocational rehabilitation and recommends participation of the mentally ill in professional life [5].

At present, there are two competing models of rehabilitation in Poland. The first is the "work creation model" based on the traditional theory of stages, and approaches vocational rehabilitation as a "step-by-step" process. It includes initiatives such as social labor projects (so-called social enterprises). Stage-based solutions allow patients to undertake specific forms of rehabilitation appropriate to their health condition. The final rehabilitation stage is to undertake a job on the open market [6, 19]. However, experience shows that reaching that stage is extremely difficult for various reasons [5]. The vast majority of patients end up at the intermediate level [6, 19]. According to Kaszyński [19] only 20% of mentally ill people are able to undertake work

in competitive conditions. The second model of rehabilitation is based on promoting supported employment in the open labor market. Advocates of this model believe that the traditional approach to occupational rehabilitation decreases the probability of finding employment [6, 19]. However, both of these models seem complimentary to each another. Kaszyński [6, 19] says that integrating these two is the only way to guarantee stable work for people with serious mental disorders.

A widely defined concept of social and vocational rehabilitation of people suffering from mental disorders in Poland includes such forms as: self-help community centers, occupational therapy workshops, vocational development centers, social enterprises, supported employment enterprises and sheltered employment [6, 19]. All of these refer to various stages of the rehabilitation process.

Self-help community centers provide social rehabilitation and support for those with chronic mental illness or mental disability. Their aim is to support patients in daily functioning, and counteract hospitalization [6, 20].

Occupational therapy workshops (OTW) support social and occupational rehabilitation of people with disability [21]. They focus on obtaining skills and qualifications essential for employment. Elements of professional counseling and assistance in finding a job is also used [20]. By the end of 2013, there were 682 such initiatives registered in Poland; however, only 18% of their users were mentally disabled [22, 23]. The effectiveness of rehabilitation offered at OTW is very limited because of insufficient cooperation with supported employment enterprises (despite the legislator's recommendations) or with the open labor market [6].

Vocational development centers (VDCs) are relatively new. The first such centre was established in 2000 to give employment or offer vocational rehabilitation to severely disabled people, and prepare patients to live independent lives and function in society [24]. At least 70% of people employed in VDCs are classified with moderate or severe disability [23]. By the end of 2013, there were 75 such centers and 54% of their employees were people with mental disorders. VDCs often provide catering or gastronomic services, management of public green space or printing services [22]. They are social economy entities which operate as non-profit companies and any profit is invested in rehabilitation of their employees [6]. The most popular VDC employing people with mental illness is a guesthouse in Krakow called "U Pana Cogito" (English: "At Mr Cogito's") [13]. Kaszyński [23] highlights that VDCs develop good practices to promote the development of social enterprises (business units established to provide employment for mentally disabled).

Social enterprises fulfill their mission by providing services or producing valuable goods and, at the same time, taking into consideration the specific needs of their employees. The primary objective is to include mentally disabled people or those with difficulties in everyday functioning in the labor market [6]. Cechnicki [25] says these companies can be the foundation of a solid employment system for mentally disabled

and real competitors to the open labor market. An example is "Cafe Hamlet" run by the Krakow Hamlet Foundation [26].

Supported employment enterprises are (contrary to social enterprises) business entities which generate profit and are focused on financial gain. At least 50% of their employees are disabled, out of whom a minimum of 20% must be classified as moderate or severe [27]. Individuals suffering from mental illness tend to be shunned from such enterprises nowadays because of economic priorities. In many cases, work offered to them is bereft of any socio-therapeutic function [6, 24]. A good example of creating workplaces in cooperation with supported employment enterprises is the EKON project [28].

The last solution is sheltered employment, which supports disabled people who are unable to find and sustain work in the open market [29]. Sheltered employment is most effective for people with minor dysfunctions [6]. An example is "Dom Warszawski pod Fontanną" (English: "The Warsaw House under the Fountain") which offers temporary employment positions [30].

Although social enterprises and other forms of socio-vocational participation facilitate an effective transfer of resources allocated for psychiatric rehabilitation [23], these initiatives seem to be underdeveloped in Poland. One of the reasons why disabled people have difficulties returning to the labor market is insufficient cooperation between institutions offering rehabilitation and potential employers [6].

Despite the value of vocational activity mentioned above, the problem of rehabilitation has received little attention in Polish literature. There are no systemized empirical studies exploring patients' experiences in the workplace, their expectations and difficulties. Our research aims to fill in this gap. It was inspired by a few published accounts of people with severe mental illness who referred to the importance of work [31]. We used interpretative phenomenological analysis [32], which is consistent with the "recovery model" in psychiatry, in which professionals "listen to the voice" of their patients and concentrate on the unique character of their experience [33]. The main research question guiding this study was: What meaning do people with a schizophrenia spectrum diagnosis ascribe to work activity?

Material and method

Rationale for using IPA

The objective of IPA is to gather comprehensive material on how individuals experience particular phenomena. IPA refers to fundamental principles of phenomenology, hermeneutics and ideography, employing a so-called "dual hermeneutics". This entails researchers' attempt to interpret what meaning participants ascribe to phenomena in their world [32, 34]. IPA involves a detailed analysis of qualitative data gathered from a small, purposeful and homogenous sample [35]. We regarded

this approach most appropriate to explore personal experiences associated with working in VDCs. We also decided that this method would help us understand the meaning patients attributed to work activity during their recovery process. This is important in order to understand potential benefits and challenges associated with coaxing these people into the professional world. Our participants spoke about their experiences with severe mental illness such as schizophrenia and schizoaffective disorder, the recovery process, and meaning ascribed to work. This paper focuses on the meaning attributed to working in VDCs.

Participants

Participants in this study were eight patients (4 women and 4 men) with schizophrenia spectrum disorders, aged 28–58. All were employed in Vocational Development Centers in Lublin, Pulawy or Leczna for 2–6 years. Five had secondary education and three had finished vocational training. All except one person (Mateusz) had previous work experience before their illness. Most had participated in occupational therapy workshops or self-help community centers. The eight participants are described in Table 1; their names have been changed to ensure confidentiality.

Table 1. **Information about research participants (N = 8)**

Pseudonym	Characteristics
Teresa	Age 42, vocational training. Single, no children. She had worked for two years at a care centre, a preschool and in a printing office before becoming ill. Diagnosed with paranoid schizophrenia at age 24. For six years she has been working as a kitchen assistant in VDC. She additionally receives health benefits. She lives in sheltered housing.
Janina	Age 48, vocational training, lives with her husband. Two adult children. She previously worked as a seamstress for eight years. Diagnosed with schizoaffective disorder at age 33. Participated in OTW and has worked as a kitchen assistant in VDC for the last three years. She additionally receives health benefits.
Jolanta	Age 56, vocational training, a widow, lives alone, has two adult children. She previously worked as a seamstress, a cleaner and in a gelatin production facility. Diagnosed with schizoaffective disorder at age 34. Participated in OTW and now works as a kitchen assistant in VDC. She additionally receives health benefits.
Karolina	Age 58, secondary school education. Lives with her husband. Her two adult children live separately. She worked as an accountant for 13 years (also during the initial stages of her illness). She had her first episode of paranoid schizophrenia at age 28, but started treatment at 33. Participated in activities at the local self-help community centre. Has been working as a kitchen assistant in VDC for 4.5 years. She additionally receives health benefits.
Paweł	Age 28, vocational training, single, no children. Diagnosed with paranoid schizophrenia at 22. Has undertaken a number of jobs, including gardening, working in a cold storage facility or being a sales representative. Participated in OTW, has been working as a kitchen assistant in VDC for three years. Lives in a rented apartment.

table continued on the next page

Mateusz	Age 32, secondary school education, single, no children. He tried to get into university but was unsuccessful. Diagnosed with paranoid schizophrenia at age 19. Has no work experience. Participated in activities held by the local self-help community centre, had 40 hours of paid internship as a waiter and started voluntary work in VDC. Receives health benefits and lives in sheltered housing.
Stefan	Age 38, vocational training, divorced, one child. Worked as a leather tanner for two years and a builder for six months. Diagnosed with paranoid schizophrenia at age 23. Has been working as a kitchen assistant in VDC for the last six years. Receives health benefits, part of which is spent on alimony. He lives in sheltered housing.
Irek	Age 44, secondary school education, single, no children. Studied administration for two years and was employed as a carer for the elderly for two years. Diagnosed with paranoid schizophrenia at age 18. Has been working part-time as a waiter in VDC for the last three years. Receives health benefits and lives in sheltered housing.

The Researchers

The interviews were carried out as part of a PhD project by the first author (A.P.) who is a psychologist (working at Psychiatric Ward of 2nd Department of Psychiatry and Psychiatric Rehabilitation, Medical University of Lublin) practicing in a psychiatric clinic for about ten years. Her experience in working with psychotic individuals enabled her to build positive rapport with participants and elicit information from them. The analysis was conducted together with the second author (I.P.), who is an academic professor and researcher at the University of Social Sciences and Humanities, and supervised the project.

Procedure

This study was conducted in VDCs in Lublin, Pulawy and Leczna between 2012 and 2014. A purposive sample was used. Participants were recruited among patients with schizophrenia spectrum diagnosis with personal experience of working in VDCs for at least two years. The researcher visited three regional VDCs which employed people with mental disorders. She outlined the research to the management and requested their consent. The management then identified people who met the criteria for inclusion. The researcher informed potential candidates about the objectives and principles of the study and asked for their informed consent. Out of 19 people, three refused – one claimed participation in an interview would be too stressful for her, and the remaining two did not give reasons for refusal. 16 interviews were conducted altogether, eight of which were then selected for analysis. The remaining interviews were rejected because they were too short or provided insufficient information, which was caused by persisting symptoms in the examined persons and cognitive difficulties, or the short duration of employment (a few days). Some

participants were also excluded because it turned out they had a different diagnosis (bipolar disorder). Participants reacted to interview in a variety of ways: some were very willing to answer questions without inhibition and others needed time to feel more comfortable with the new situation and the necessity for recording the conversation. A number of participants expressed their surprise that anyone would be interested in their private opinions about their illness or treatment. Each interview lasted 40–60 minutes and was digitally recorded.

Interview protocol

We used semi-structured in-depth interviews to gather information about participants' personal experiences associated with illness, recovery process, and meaning attributed to work. Before gathering data we identified key areas to be explored with each participant, including: family situation, the history of illness and treatment, professional experience prior to illness, the effect of illness on career development, and experience associated with psychiatric rehabilitation. Open-ended questions and prompts were prepared to explore these areas and encourage participants to share their memories, thoughts and feelings. The researcher discussed these areas with participants and asked additional questions for clarification or exploration of topics which emerged spontaneously during interviews.

Data analysis

We produced detailed, verbatim transcripts of all audio recordings and analyzed them in Nvivo10 (computer-assisted qualitative data analysis software) using the consecutive analytical steps recommended for IPA [30]. First, we listened to each recording and read the transcripts carefully several times. We then used the "annotation" tool in Nvivo10 to produce extensive notes about the content and language use, and registered our interpretative comments. All notes were then categorized into emergent themes by allocating descriptive labels. We discussed our coding and interpretations with each other and followed the same procedure for each interview. We then compared the themes between participants to check that they were represented in all interviews. We also analyzed connections between themes in each interview and between cases, and grouped themes according to conceptual similarities into superordinate ones and sub-themes. This final report presents an elaboration of main themes and sub-themes associated with work experience in VDCs.

Results

All participants in this study gave detailed accounts of their experiences associated with working in VDCs. They talked about the significance of work activity in

their lives and the process of treatment, advantages, but also challenges associated with working in VDCs. In the course of analysis we identified five main themes (presented in table 2). We describe them in detailbelow, including excerpts of participants' own words.

Table 2. **Emergent themes identified during analysis**

Main themes	Number of participants with the theme
1. An activating function of work	6
2. Positive self-image of employee	5
3. A sense of community	7
4. Financial gratification	8
5. Work-related burdens	8

An activating function of work

Working in a VDC involved adherence to certain tasks and work schedules. Many participants found that going to work regularly gave them a sense of structure, predictability and a feeling anchored in reality. Stefan talked about signing his job contract as an important achievement and felt obliged to fulfill the duties entrusted to him, even in periods of low mood:

> *I don't really feel like doing anything. Perhaps I'm a bit depressed. I simply wake up and don't feel like getting up. I think to myself that this day is going to be hard, boring and irritating, but I am employed here, after all. I've signed a contract and I cannot neglect that.*

Having responsibilities and a chance to demonstrate their skills helped participants find meaning in their lives, empowerment, and had an activation function. Karolina noted that "work motivates me to get up in the morning". Otherwise, she would probably avoid social contact and simply stay in bed. Paweł also stressed that responsibilities at work encouraged him to be active and go out:

> *Work teaches me consistency and reliability. I don't know how to express that. For example, I start work at six in the morning, so it motivates me to get up. I know that others would stay in bed and do nothing. I get up, wash myself, and go to work. The fact that I get up and go to work gives me strength to carry on working.*

He stressed the importance of getting up at a specific time and taking care of his personal hygiene. Another participant also spoke about looking after her personal appearance because she interacts with people at work and wants to avoid negative comments:

> *If you have a job, you need to look after your appearance. People like me, in my opinion, often neglect themselves. They don't care about being well-dressed or having tidy hair. This is not important any more. But when you go out and see people, well, you really have to buck up a bit, to avoid critical comments. You dress nicely, comb your hair, put on some make-up and go to work.*

Teresa compared her activity at home and at work. She realized that the presence and involvement of VDC staff encouraged her to be more active. The management seemed to play an essential symbolic role for her as caregivers, who encourage and support her in undertaking challenges and commitments. "Working here you have to do this or that. Because one must do that, you simply engage yourself in these activities. At home, however, no one encourages you. Here it looks different."

Stefan ascribed similar value to VDC personnel. He perceived detailed instructions received from them as encouraging and empowering, especially when he was feeling lost. "They tell you exactly what to do. They motivate you to work. If I had to do something from start to finish myself, I wouldn't know where to begin."

Positive self-image of employee

Being able to work and show their abilities in a variety of tasks had positive effects on participants' self-esteem and self-efficacy. Marta was proud to be able to use her skills: "I am quite good at what I do, and I can do things properly. I am quite fast, which is good. There is no queue when I distribute meals." Janina said that contact with other employees at the VDC encouraged her to hope that she could be useful in society and helped her cope with stereotypes she thought people had about disabled people, and which she herself internalized. She was able to incorporate her professional role into her self-image, instead of constructing her own identity mainly on limitations or deficits associated with illness and the role of a patient.

> *When I saw that such people can still work, that they can be given a job, this really touched me. It really warmed my soul. People say: "The disabled, what can they do?" I have heard such comments. It is so important to actually do something, so that you're not an outcast from society.*

Participants were grateful to have employment and strongly identified themselves with their workplace. Janina referred to her job as her "own place, a dream that came true, my second home". Karolina also believed that disabled people get attached to their workplace and exercised special efforts because of the limited number of places that can offer employment to people with mental disorders. Teresa said that her dedication to the VDC helped her make sense of her engagement.

Irek highlighted a specific inversion of role while serving as a waiter during events to which doctors or priests were invited. Those who normally provided him with support and help became the recipients of his services. This allowed him to enter into a variety of social roles (not only that of an ill or disabled person) and give him a sense of payback. This had significant meaning for him when those who represented authority expressed their gratitude and appreciation: "it is so nice when people thank us for our services and say that the meal was delicious. Last time we even got a box of chocolates for working as waiters during a baptism celebration"

Other participants also expressed satisfaction when their efforts were recognized and appreciated by management or clients, especially when they lacked such experiences elsewhere. "I really feel valued. Sometimes I do something and someone says it is nice or good. I really like baking; the thing is, I don't do such things at home because I don't have anyone to do that for" – Karolina.

Responsibilities given to VDC employees were similar to the chores they had at home. Participants said expectations of them at their workplace were adjusted to their abilities, which increased their self-efficacy. The type and scope of assignments was usually individually negotiated, depending on the mental state and capabilities of an employee. Participants felt they were working in a sheltered environment and could count on more understanding when compared to healthy individuals. Irek says:

> *This tolerance really helps me. A year ago I was on some new medication. We were doing a catering job and the manager wanted me to prepare something, but I was unable to stand up straight. Wherever I sat down for a moment, I immediately fell asleep. If this happened in a typical workplace, the café manager would probably ask: "Have you been taking drugs or something? Are you still drunk after a party?" Whereas here, I just told the manager that I was taking new medication for the first time, and she totally understood.*

Only Stefan declared a different approach towards his work. He compared himself to other employees and diminished the value of the tasks allocated to him. He saw himself as someone with no skills at all and said his job did not really match his interests: "I know that the cooks have many more responsibilities on their hands. What I do in comparison to them is simply less important. If it wasn't for them, there would be no meals available. I don't really do anything important here, because I am only a kitchen assistant".

A sense of community

Having regular work provided a chance to interact with other people, which helped some participants break the feeling of social isolation. Teresa stressed how important this was for someone who was single and without social networks: "I have

some friends. One is not so lonely any more. You can talk to someone and someone will listen to you". Mateusz emphasized that work gave him a chance to "participate in social life". There were other people in VDCs struggling with similar difficulties. Identifying with them helped form a sense of community and lessened the feeling of separation. Stefan says: "I know that I am not alone. A few people here also have paranoid schizophrenia. I know I'm not an exception. It's a relief to think you are not the only one with this problem".

Participants say that shared history of illness brings people together because patients can understand the difficulties and challenges experienced by those in psychiatric treatment. Karolina says: "other patients know that there are better and worse days; that sometimes one is agitated, sort of nervous". In this way, they could become experts-by-experience. Irek says that, although employees do not always discuss their symptoms with one another, a mere awareness that they share similar experiences is very comforting:

> *I know all that from my own experience. I don't talk too much with the girls about that, but ... sometimes this fear just happens. No one really knows why that anxiety appears, or why one is so hyped-up again. It's just part of this illness.*

According to Karolina, healthy people cannot fully comprehend the difficulties experienced by those with mental illness.

> *We really understand one another well because we have lots in common. One knows how hard it is sometimes, how mentally tortured you feel, sometimes. This is something that a healthy person can't really understand, I suppose. So, there's no point talking to someone like that about your illness because it doesn't serve for anything.*

On the other hand, participants reported feeling more accepted at VDCs and were convinced they could expect more understanding and social support, not only from the co-workers, but also from the management. Karolina says: "when it gets really bad, well, then I call them and say that… for instance, I haven't slept all night or that I only slept for two hours. Then they understand and give me a couple of days off".

Because of this, they experience less embarrassment and fear of being criticized. Janina stressed that: "in no other workplace could I experience more warmth, than here".

Financial gratification

Receiving a salary for work carried out was itself a factor which linked participants to reality and the principles of social functioning. They described their developing sense of independence and self-control. They were happy to be financially rewarded for their efforts, and this motivated them to learn how to manage their own budgets. This also had a positive effect on their self-esteem. Paweł says:

> *This was helpful because I have become more independent recently. I need to manage my money so that I have enough till the end of month and my next salary or the health benefits. I need to think about paying for my flat, bills, and things like shopping. Of course, this also teaches me to save money.*

Salaries at VDCs, although fairly low, enabled participants to meet certain needs and realize personal plans. Teresa was saving money to buy new furniture ("I saved some money because I've been planning to buy a new wardrobe. I will still have a little bit left. I can satisfy my needs. I can afford that myself.") and Stefan managed to set up the Internet at home.

Jolanta, on the other hand, viewed the salary received at VDC as a bonus to her pension. She put the money aside for unforeseen expenditures. Jolanta said: "I am saving for a rainy day, as the saying goes". She claimed that the accumulated financial resources gave her a sense of security and independence. Karolina voiced a similar approach. She was glad to be able to earn extra money to supplement her low health benefits:

> *I am happy that I work because I am already at retirement age. I was classified able to work in a sheltered environment, which does not conflict with my health benefits which is low anyway. Earning a bit extra gives me quite a nice, little salary.*

Irek, who works as a waiter, also mentions tips which he has received from satisfied customers. He did, however, express ambivalence about being tipped. On the one hand, he felt his work was appreciated. On the other hand, he was afraid of being accused of demanding tips from diners, a behavior he had witnessed at a restaurant in town. Perhaps this reveals his fear of his own greed and imagined punishment or envy from his co-workers:

> *Six months ago we were waiting at a big hall and this man came up at the end of dinner and pushed a few notes into my hand. I knew this was money so I said I couldn't accept it because I was simply doing my job. I said that tipping was not expected in our system, and so on. He told me: "Listen, take the money, because I appreciate good work." So, it was 40PLN [ca 10 Euro]. There were two other waiters there and the manager, so I decided to split the money evenly and each of us received 10 PLN. It is not that we are greedy because 10 PLN is not a huge amount of money, but it is really nice proof that someone likes the work we do.*

Work-related burdens

Apart from advantages associated with work in VDCs, participants also described a number of challenges and difficulties, including conflicts with the management, co-workers, and clients. Although conflictive situations evoked strong emotions in participants, they talked about them reluctantly. This gave the impression they were ashamed of being disloyal and wished to hide anything they thought might show the VDC in a bad light, in a similar way that children try to protect a good image of their own families.

When talking about her conflict with management, Karolina continuously highlighted her loyalty and identification with her workplace:

> *It was a very difficult experience for me, but my wounds healed after a while. Everything comes back to normality. I am not used to picking on someone but, when someone gets me going – and I am a nervous person – then we might have a tiny conflict. It happens rarely, though, because I am on their side [I am a VDC employee]. I try to do my job properly.*

While Karolina described herself as a nervous person and was able to express her discontent, Teresa was afraid of anger and avoided situations involving open conflict: "I didn't want any fuss. Who needs that? I prefer peace and quiet." According to Janina, the medical personnel working in a hospital which VDC supplied with meals assessed the work of disabled people in a negative way. Joan thinks these clients are less tolerant of errors: "in our hospital, if you forget something because there is simply a lot of work, or if you get something wrong, they make a big deal out of it. They say we can't do anything".

Participants mentioned a range of other difficulties, including tensions associated with difficult working conditions and troublesome symptoms exhibited by co-workers. Mateusz complained about feeling tired with excessive work entrusted to him, and having to work in a standing position for long periods and under time pressure. He says: "when there is more to do and the pace is increased, it gets really stressful". Paweł also talked about feeling helpless about the behavior of others, which he interpreted in terms of illness symptoms. He was angry that the VDC management did not intervene. He thought they should notice and control this sort of behavior for the benefit of other employees.

> *The only difficult thing here is some obsessive behavior of a colleague of mine. His symptoms are just so tiring. I am completely spent, physically and mentally, just because of him, by listening to him and by looking at him. This has a bad influence on me and there is nothing I can do. They should do something about him – his doctor, or people managing this place.*

Participants encountered various challenging situations typical of most workplaces which tested their ability to solve interpersonal conflicts, or cope with stress. Subsequently, some experienced elevated tension which could deteriorate health conditions in those with weaker ego functions. On the other hand, successful coping could become the source of satisfaction and pride.

Discussion

This study explored the meaning patients working in VDCs attributed to their professional activity. Participants were more inclined to discuss positive work experiences than difficulties. The analysis of interview transcripts shows that work activity was of significant value to them. This confirms findings of the American study conducted by Dunn, Wiewiorski and Rogers [36], whose participants strongly identified themselves with their workplace and claimed that work helped them to return to health. Trzebińska and Dziewulska [37] suggest that work activity can have a positive effect because it is one of the few available solutions for personality reintegration. This seemed to be the case in our research. Positive experiences associated with work (e.g., a sense of being appreciated) led to higher self-esteem and enabled a transition from feeling useless, worthless, and identifying oneself solely with a patient's role, to viewing oneself as a valuable employee. Working in VDCs and establishing relationships with others made illness just one aspect of everyday functioning that had an impact on self-identity. According to Krupa [38], the role of an employee leads to focusing on work and responsibilities, limiting the disorganizing effect of the symptoms of illness. Our results are consistent with the American and Canadian studies which indicate that work, appropriately adjusted to individual abilities and preferences of an employee, positively effects self-esteem and a sense of achievement and pride [36, 39]. Stefan was the only participant in our study who thought his work was boring, assessed his competences as very low and felt useless at work. Satisfaction with work activity thus needs to be adjusted to the interests and preferences of the jobseeker. Another important advantage of professional activity is that it can help cope with stigmatization and internalized social stigma. Having the status of an employee and a chance to experience oneself as competent, and not only a person with mental disorders, is very important [40]. It is essential, therefore, that professionals empower their patients and help them to recognize their resources and areas for potential development, rather than concentrate on limitations and losses associated with illness. Killeen and O'Day [41] highlight that many poorly functioning patients can still improve and pursue some career. For this reason, Cechnicki and Liberadzka [33] advocate recovery-oriented rehabilitation and highlight how ineffective is the approach focused on deficits. On the other hand, one must not forget that employees of VDCs can realistically encounter situations in which they will feel stigmatized, which can have an adverse effect on their self-esteem. One of our participants felt that clients' appraisal of the work performed by VDC workers

was negative only because these workers were disabled. Psychiatric rehabilitation should thus include activities that help patients cope with social stigmatization and discrimination.

Our research has shown that one of the most essential functions of work is its mobilizing aspect. It activated and stabilized our participants by providing them with structure and rhythm. It also gave sense to their actions and empowered them. An ability to draw satisfaction from being able to fulfill one's responsibilities helped them cope with illness and associated emotions. This is consistent with Dunn, Wiewiorski and Rogers [36], whose participants claimed that no other activity had such a positive effect on their health. The demands of work encourage people to adhere to social norms and develop their interests, skills and resources [38]. On the other hand, some of these demands, even in sheltered employment, can be perceived as excessive and induce fear of failure, which can have an adverse effect on health. Not all patients see professional activity as a path to recovery [41]. Our participants said that excessive work under time pressure was burdening, especially when co-workers were on sick-leave. It is thus necessary to take care that job demands do not exceed an employee's abilities and that the job function and responsibilities are adjusted to his or her qualifications, physical and mental condition [37]. This justifies a need for assistants of a disabled person to be present at workplaces – especially where people take on a new job for the first time in their lives or after a long break. Supervision from someone outside the VDC management may also be sensible.

Work activity counteracts social isolation by allowing people to identify with others with similar problems. The results of our study are consistent with Leufstadius, Eukland and Erlandsson [42] who show that work environment can provide a sense of affiliation and community. Support and good relationships with management or co-workers can become a holding environment that is beneficial for the mental state and shields from relapses [39]. However, conflicts are also an inevitable element of human relationships and can lead to intensification of symptoms. This is especially relevant because people with schizophrenia can be overly reactive to any display of negative emotions by others [37]. Our participants were disinclined to talk about conflicts with superiors or co-workers, and were afraid to express their own anger and, in most cases, they undermined the significance of such situations. It would be valuable to further explore how people with mental illness cope with conflictive situations at work and emotions associated with them. Our participants described VDC personnel as understanding and supportive, but that they did not often intervene in conflicts between employees. Participants themselves would not report difficult situations to the staff (e.g., when a team member presented disturbing symptoms) because they expected their superiors to notice and react spontaneously. This implies that patients felt highly dependent on authority figures and need to be encouraged to express their opinions and needs openly [40]. For this reason, workshops in stress management addressing the needs of people

with mental disorders should be initiated as an element of vocational rehabilitation. These patients should also be encouraged to use psychological counseling to improve their coping strategies.

Financial gratification was another element affecting professional activity experience. This was connected with planning budgets, a sense of control, independence and security, and also strengthened the connection with reality. Remuneration can also be a source of pride and provide a sense of achievement [36]. Our participants were happy with their salaries, even though they were low and served as an additional bonus to their health benefits. Others [43] thought that receiving health benefits itself limit the motivation to pursue work and give up secondary gains associated with illness or disability. Although health benefits provide some sort of security, especially at periods of deterioration, it does not encourage job-seeking in competitive conditions. Resigning from entitlement to health benefits is a risk that requires self-belief, a sense of agency, and friendly surroundings. On the other hand, the rates offered at VDCs are more like pocket money than a substantial salary, so working in a VDC is more like training. Only full-time employment in competitive conditions could potentially allow patients to become independent and self-sustaining. This only seems possible for well-functioning patients or those with significantly valued skills (artistic for instance).

According to Brown and Kandirikiri [44], factors that help patients undertake professional activity are: a flexible and supportive attitude from others, going at one's own pace in seeking a job or returning to work, recognizing the most sensible form of activity for oneself, and job-satisfaction. This is consistent with our study. Despite evidence that work can have a therapeutic effect [11] and declarations made by the majority of mentally ill patients that they would like engage in work [15, 45], only a small fraction of them participate in vocational development programs and have taken up work in the labor market. Reasons for that were discussed by multiple authors [11, 19, 28, 37]. It seems that the major difficulty in Poland is the lack of integrated rehabilitation and vocational development, which would be linked with the labor market and be attuned to the different needs of people suffering from mental illness. Legislative solutions supporting various forms of employment based on donations are also needed [6, 46]. The hospital-centered model of patient care also presents a serious problem. Despite initial hopes in the National Mental Health Program, most tasks listed here have not been implemented, leading to structural discrimination of people with mental disorders [47]. Not only are their needs neglected at the central and regional government level, but they also face social stigmatization, which limit their access to employment even more [47, 48].

Accounts relating to recovery shared by our participants show that psychiatric rehabilitation and vocational development have substantial value, especially in areas where pharmacotherapy has limited effects. Medication helps to reduce symptoms, but the participants still isolate themselves and have problems with everyday functioning.

Morrison et al. [49] say that psychiatrists are over-reliant on antipsychotic medicines. The assumption that there are no alternative solutions may result in underestimating psychiatric rehabilitation and limit patients' development. This attitude remains, despite limited efficacy of antipsychotic drugs shown in recent meta-analysis [50]. Various authors also highlight adverse effects. Moncrieff and Leo [51] indicate that antipsychotic medicines can cause structural changes in the central nervous system which used to be attributed to schizophrenia itself. Beng-Choon et al. [52] reach similar conclusions, and encourage psychiatrists to exercise caution in planning doses or the length of treatment, and consider potential benefits and harm. Although certain patients have positive reactions to antipsychotic medication, others do not show improvement. Nevertheless, they are encouraged to continue treatment despite adverse effects. Our participants expressed ambivalent attitudes towards pharmacotherapy. Many complained about its negative effect on cognitive and motor function which limited their ability to perform even simple professional tasks. For similar reasons, many chronic patients realistically lose hope of ever returning to work, study, or establishing a family. That is why patients are often reluctant to have pharmacotherapy (especially long-term). Lieberman et al. [53] observe that among 1,493 patients, 74% discontinued treatment, inter alia, because of adverse effects. Alternative solutions are thus encouraged by various authors, especially when antipsychotic treatment does not produce expected improvement. Morrison et al. [54] show promising results of a study on using cognitive-behavioral techniques instead of pharmacotherapy to reduce distress and improve life satisfaction. In Finland, only 33% of patients with psychosis who used the Open Dialogue method needed to take medicine. 84% of them were able to return to their studies or full-time work after such treatment [55]. Knafo and Selzer [56] provide another interesting example of using psychodynamic psychotherapy to treat a patient in psychosis. They advocate a change in contemporary medicine that has focused on using pharmacotherapy to eliminate symptoms. Instead, authors say, professionals should try to understand the function and meaning of these symptoms. More frequent use of psychotherapy in psychiatric rehabilitation and greater caution in using pharmacotherapy (especially outside periods when functioning is diminished) can stimulate patient development and result in fewer adverse effects which can, in the long run, limit the ability or even disable professional activity.

Limitations and further development

This was an exploratory and highly idiographic study focusing on the work experiences of people living with severe mental illness. Lee and Tracey [57] emphasize the practicality of such analysis, as it facilitates building hypotheses and preliminary hypotheses which can later be verified through quantitative examination. The theme of vocational activity among people with mental illness justifies further enquiry for a better understanding of mechanisms underlying successful rehabilitation and pro-

fessional development. It would be interesting to hear from people who did not agree to participate in this study. They could represent a separate group with whom we could spend more time to build rapport and obtain information about how they view work in VDCs. It would also be useful to explore work experience at different stages of vocational rehabilitation and in groups who have undertaken employment in the labor market. This would help us build a more thorough picture of the problem under investigation. Analyzing challenges experienced by patients (especially situations of conflict which our participants described with reluctance) and their coping strategies would be important. Another problem that yields further exploration is losing a job due to mental illness. There are situations when people with specialized educational backgrounds, or who perform responsible tasks that require complete cognitive or motor functions, become ineligible to work because of symptoms of illness. What they would make of these situations, and how that affects their identity and self-esteem, should be explored.

A few practical implications arise from this study. First of all, establishing local programs focused on vocational development and using an integrated model of community support [46] should be encouraged. Specific tasks outlined in the National Mental Health Program should be developed. Cooperation should also be fostered between individuals and institutions involved in rehabilitation and vocational development of people with severe mental illness: doctors, social care, job centers, employers and local governments. Social campaigns should be continued to improve a general perception of people with mental disorders and to promote the therapeutic function of work in this group [48]. Healthcare professionals should also be educated about the meaning of work and available solutions in rehabilitation and vocational development. Developing a central database containing information about institutions providing vocational development which could be accessed by doctors, patients, and potential employers is also justified.

Conclusions

1. Professional activity positively affects self-esteem, activates patients and helps them to break social isolation and build a sense of independence.
2. Cooperation should be fostered between individuals and institutions involved in rehabilitation and vocational development of people with severe mental illness.
3. A central database containing information about vocational development for people with severe mental illness should be accessible online for all stakeholders.
4. Challenging situations which induce stress at the workplace and risk greater deterioration of symptoms should be explored.

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