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Gainful Employment Reduces Stigma Toward People Recovering from Schizophrenia

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Abstract Stigma impedes the social integration of persons recovering from psychiatric disability, especially those with criminal histories. Little is known about factors that lessen this stigma. Four hundred and four adults listened to one of four vignettes describing a 25-year-old male with schizophrenia and responded to a standard set of items measuring social distance. The individual who was gainfully employed (vs. unemployed), or who had a prior misdemeanor (vs. felony) criminal offense, elicited significantly less stigma. Employment may destigmatize a person coping with both psychiatric disability and a criminal record. Mental health services should encourage paid employment and other paths to community integration.

Keywords Stigma · Employment · Criminal involvement · Recovery

Introduction

Most people recovering from serious psychiatric disabilities, such as chronic schizophrenia or other major mental illnesses, now live in the community. In theory, living in the community better enables such individuals to pursue recovery, which can be conceptualized as enjoying a quality of life that approximates what the individual would experience if not disabled. Recovery encompasses internal processes as well as external factors such as interactions with the environment (Jacobson and Greenley 2001). Employment, education, and the fulfillment of community roles are all important aspects of the recovery process (Ware et al. 2007).

The impact of societal stigma (e.g., social avoidance and rejection, low expectations, prejudice, and discrimination directed at an individual or group) poses a challenge to the full social integration of persons with psychiatric disabilities (Corrigan 2004), since it interferes with their efforts to develop friendships, find employment, or join organized groups and community activities. Evidence suggests that there are numerous negative consequences that follow from stigma (Kommana et al. 1997; Link et al. 1992). Persons with psychiatric disabilities are more likely to be unemployed, have less income, experience devaluation, and have a limited social support system (Link and Cullen 1990). Negative public perceptions of individuals with psychiatric disabilities create obstacles to the formation of social networks often making the individual more vulnerable to stress (Kommana et al. 1997) which may contribute to the likelihood of future relapse (Penn and Martin 1998). Widespread societal rejection of persons in recovery can also lead to devaluation of the self through self-stigma (Corrigan et al. 2006). The internalization of stigmatizing attitudes may result in "…depression, increased anxiety, lower self-esteem, and the adoption of secrecy and withdrawal as coping strategies" (Penn and Martin 1998, p. 236).

Employment is viewed as an essential aspect of psychiatric rehabilitation yet unemployment rates among

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people with psychiatric disabilities have been reported to be three to five times higher than among those with no disorders (Sturm et al. 1999). Employment-related stigma and discrimination have been identified as significant barriers to employment success for those with psychiatric disabilities (Baron and Salzer 2002; Stuart 2006). In their study examining barriers to employment, Johannesen et al. (2007) found that the majority of individuals in recovery reported that having a psychiatric disability was a significant concern in finding employment. Participants who initially identified more barriers to employment were less likely to find and maintain employment.

Research has identified characteristics of people with psychiatric disabilities that increase the likelihood of social stigma, such as illness symptoms, social skill deficits, and physical appearance (see Corrigan et al. 2008, Chapter 2), but aside from prior contact (Pettigrew and Tropp 2000) and increased familiarity with mental disabilities (Corrigan et al. 2001) there has been less research on factors that destigmatize people with psychiatric disabilities. Given the strong and pervasive influence of stigma on opportunities to participate in work, might overcoming barriers and obtaining gainful employment reduce the amount of stigma? What about people with disabilities who are also stigmatized for other reasons? For example, individuals with both mental illness and a history of criminal involvement are a significant proportion of consumers served by community mental health centers (Theriot and Segal 2005). Individuals with mental illness are often perceived to be dangerous or untrustworthy (Mehta and Farina 1997). These perceptions coupled with a history of actual criminal activity can lead to substantial limitations in community integration opportunities for those with such a background.

Barriers to employment and education, and the level of poverty experienced by many with psychiatric disabilities often lead individuals to "live in neighborhoods, housing projects, homeless shelters, and other settings that are rife with illicit substances, unemployment, crime, victimization, family breakdown, homelessness, health burdens, and a heavy concentration of other marginalized citizens" (Draine et al. 2002, as cited in Fisher and Drake 2007, p. 545). Fisher and Drake (2007) suggest that these circumstances and the result of multiple policy breakdowns "magnify the risk of criminal offending" (p. 546). Morrisey et al. (2007) summarized recent criminal justice statistics and found that individuals with psychiatric disabilities are "jailed more often than they are hospitalized" (p. 532). In fact they found that the "relative annual risk of a person with severe mental illness being detained in jail is 150% greater than admission to any type of hospital for inpatient psychiatric care, and 800% greater than admission to a state psychiatric hospital" (p. 533). Fisher et al. (2006) found that minor offenses, such as public disturbance or petty theft, often lead to time in jail for individuals with psychiatric disabilities, but felonies, especially those associated with illicit drugs are also common.

Criminal history is a challenge in employment opportunities; "any criminal history, no matter how minor or how far in the past, can potentially penalize a client seeking employment" (Massachusetts Department of Mental Health 2006, p. 12). Tschopp et al. (2007) found that stigma related to both mental illness and criminal background was a significant barrier to achieving successful employment outcomes for these individuals. A stigma hierarchy based on type of offense was also indicated (Tschopp et al. 2007). For example, a focus group of supported employment service providers agreed that sexual offenses and theft were the most stigmatized by employers and created the most barriers to employment opportunities. Also, since perceived dangerousness is an important factor influencing stigma (Link et al. 1987), persons in recovery who have histories of past criminal involvement may elicit different degrees of stigma depending on whether the past offense was a misdemeanor (e.g., underage drinking) or a more serious felony (e.g., arson).

Since reducing stigmatizing attitudes toward individuals with mental illness is key to fuller community integration (Mann and Himelein, 2004), it would be useful to see if the destigmatizing effect of gainful employment extends to individuals who are doubly-stigmatized (that is, have both mental illness and a criminal history). In operationalizing stigma for this study, we focused on social avoidance and rejection, a dimension of stigma measured by many investigators over the past 75 years using a standard set of "social distance" items (e.g., see Link et al. 1987). Our hypotheses were that:

Hypothesis 1: An adult male with schizophrenia who is *actively engaged in competitive, wage-based community employment* will elicit less social distance than one who is *unemployed*.

Hypothesis 2: An adult male with schizophrenia who has a past history of *misdemeanor* criminal conduct will elicit less social distance than one with a past history of *felony* criminal conduct.

Methods

Participants were 404 adult residents of Delaware County, Indiana (also known by the pseudonym "Middletown" and long a source for survey samples as a typical American community). A list of 2,039 random phone numbers for the county was purchased from Marketing Systems Group using a list-assisted, random digit dialing technique (which,

despite the proliferation of cell phones and other in-home technologies such as caller ID and voicemail, remains the most effective sampling procedure for telephone surveys; Kempf and Remington 2007). Of these records, 607 numbers were ineligible (e.g., businesses) and 412 residents did not answer repeated call attempts (minimum of four attempts on various evenings); 1,019 eligible persons were reached, of whom 404 (39.6%) completed an anonymous interview and 616 declined to participate. Oral informed consent was secured at the time of the interview.

The interviewer began by reading one of four vignettes describing a fictional 25-year old male diagnosed with schizophrenia living in the community. To create this description we adapted a 115-word vignette depicting a male with schizophrenia (based on *DSM-IV* criteria) used by Link et al. (1999). With advice from a past president of NAMI-Indiana who has considerable first-hand experience with schizophrenia, we added a few descriptive details to make the symptoms more vivid and concrete. In all four vignettes the individual had identical symptoms, the same degree of involvement in psychiatric treatment, and a prior criminal conviction, but in one condition he worked 20 h per week and his past conviction was for a misdemeanor alcohol offense, in a second he worked and had a past conviction for felony arson, in a third he was unemployed and had the misdemeanor alcohol conviction, and in the final condition he was unemployed and had the past felony arson conviction. The final vignettes were kept succinct (244–252 words) to limit extraneous or distracting information and to make each vignette brief when read over the telephone.

After listening to the vignette each participant indicated social distance by how willing (1 = definitely; 4 = definitely not) s/he would be to (1) move next door to the person depicted in the vignette, (2) spend an evening socializing with him, (3) make friends with him, (4) start working closely with him, and (5) have him marry into the family (see Link et al. 1999). Participants also evaluated the fictional person's propensity for violence and contribution to his community, indicated whether they, or any of their friends or family, had ever received treatment for a mental health problem, and provided demographic information. The study was approved by the Ball State University Institutional Review Board, the authors have no known conflicts of interest in connection with this research, and all authors certify responsibility for this study.

All participants were 18 years of age or older; 67% were female, 91% were Caucasian, their mean age was 52.18 years ($SD = 16.08$), 40.9% had at least a 2-year college degree (41% had a high school education or less), 46% had family incomes of less than $40,000 per year (29.2% had family incomes over $60,000), and 49% of respondents reported that a friend or family member had received treatment for a mental disorder.

Results

Using a one-way analysis of variance (ANOVA), results confirmed that the experimental manipulations were effective: participants perceived the individual as more likely "to do something violent towards other people" when he had committed a past felony instead of a misdemeanor, $F\ (1, 380) = 4.55$, $P = .03$, and perceived him as more likely to "be a productive member of his community" if he worked, $F\ (1, 395) = 16.28$, $P < .001$, and if he had committed only a misdemeanor offense, $F\ (1, 395) = 6.98$, $P = .009$. Using factor analysis with varimax rotation, the five social distance items loaded (0.72–0.83) on a single rotated factor and showed high internal consistency (Cronbach's $\alpha = 0.87$). Responses to the five social distance items were summed and divided by 5 so that scores could range from 1 (low social distance) to 4 (high social distance) to represent an index of overall social distance (Link et al. 1999).

Social distance scores were subjected to a 2 (work status) × 2 (criminal offense) ANOVA. Our first hypothesis was confirmed: the male with schizophrenia who was working elicited significantly less social distance (mean = 2.15, $SD = 0.63$) than did the male with schizophrenia who was not working (mean = 2.27, $SD = 0.59$), $F\ (1, 401) = 3.81$, $P = .05$. Our second hypothesis was also confirmed: the male with schizophrenia who had a past misdemeanor conviction elicited significantly less social distance (mean = 2.14, $SD = 0.64$) than did the male with schizophrenia who had a past felony conviction (mean = 2.27, $SD = 0.61$), $F\ (1, 401) = 4.30$, $P = .04$. A plot of these means is displayed in Fig. 1. There was no significant interaction effect of work

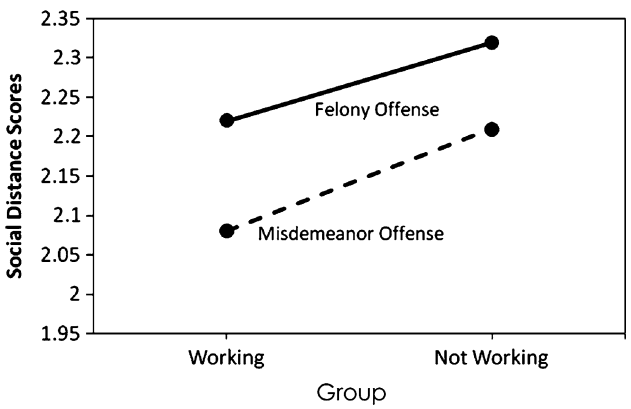

Fig. 1 Mean social distance scores by work status and criminal offense group

status and severity of past criminal offense on social distance ($P = 0.83$). Social distance was also less if the survey participant had a friend or family member who had been treated for a mental health problem (mean = 2.09, $SD = 0.60$) than if s/he did not (mean = 2.30, $SD = 0.62$), F (1, 399) = 11.55, $P = .001$, but this difference had no effect on the other results in this study.

Discussion

Gainful employment and a criminal history of committing only a minor offense (vs. a felony) independently reduced the stigma shown by adults towards a fictional person coping with both schizophrenia and a criminal record.

Work status did not interact with severity of criminal offense, indicating that the destigmatizing effect of employment is the same for individuals with felony offenses as for individuals with misdemeanor offenses, and that the reductions in stigma from working and from less serious criminal involvement are additive.

Social distance was about the same for the individual with a felony who was working (mean = 2.22) as for the individual with a misdemeanor who was not working (mean = 2.21), suggesting that gainful employment, even if only part time, destigmatizes a person who has both schizophrenia and a felony criminal record. That is, in the same way that a single detail (e.g., a felony criminal record or diagnosis of schizophrenia) can outweigh a host of other characteristics to negatively influence others' impressions of an individual, knowing that an individual is gainfully employed has a contrasting positive influence on one's impression, even in people who have had friends or family members treated for a psychiatric disability. Gainful employment thus counteracts the stereotype that many people hold of an individual with a psychiatric disability, helping an observer recognize a person in recovery rather than a label.

In terms of this study's limitations, the results were obtained from one Midwestern community, suggesting that they may or may not generalize to a broad range of communities. Also, the proportion of study participants who were female was somewhat larger than in the population sampled (which is typical for telephone surveys). Finally, the study used fictional vignettes, and the social distance someone prefers in the context of an actual relationship with a person in recovery would likely reflect additional interpersonal details (such as the individual's racial ancestry).

Implications for Practice

A key step in recovery from psychiatric illness is initiating and maintaining reciprocal interpersonal relationships (Ware et al. 2007). Our results suggest that gainful employment aids this process by directly reducing the negative interpersonal perceptions held by adults in the community toward persons coping with psychiatric illness and past criminal behavior. Given the financial, social, and psychological benefits of working, the finding that it also destigmatizes people in recovery suggests that services should emphasize paid employment and other paths to community integration, such as volunteer opportunities in fully-integrated community settings. In particular, there should be more attention to vocational recovery for persons who have psychiatric disabilities and are involved in the criminal justice system. Morrisey et al. (2007) see such individuals as a special population that has not adequately benefited from existing mental health models.

Another important element in enhancing recovery for individuals with psychiatric disabilities and changing public perception is the need to reduce recidivism in treatment. Lamberti (2007) cites enhancing success in school and or work as key strategies for reducing recidivism. Moreover, Johannesen et al. (2007) found that self-perceptions of barriers were related to work behavior and functioning, and suggested that interventions to change the perceptions of persons in recovery, as well as their self-advocacy skills, would be important avenues for enhancing vocational rehabilitation outcomes. Finally, strategies for decreasing stigma and changing public perception should also be focused on environmental issues such as building awareness and educating the community. Advocacy through educating employers and other providers in collaborative systems is crucial and should be a focus of training for those serving individuals with psychiatric disabilities.

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