

“I Don’t Want to Make Candles!”

Supporting the Career Development Needs of those Recovering from Mental Illness

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As a quintessentially human activity, work transcends countries and cultures. But as economies falter and labor markets go global, the concept of career can seem unrealistic—even alien—to many in economically developing and developed nations alike. The challenge to today’s career professional is providing relevant services in the face of rapid, pervasive change.

Abstract

The care of persons with mental disorders has changed radically over the last two hundred years, from a situation of exclusion in special institutions to the current approach of care in the community. Hence, career development strategy has become an important, new addition to emerging paradigms of rehabilitation models. In this chapter focus is brought to bear on the interface between three disciplines: psychology, psychiatry, and career guidance and counseling. The barriers created by social stigma and a misplaced emphasis on disability are discussed. The International Classification of Functioning, Disability and Health (ICF), is presented as a conceptual framework for the career counseling of those recovering from mental illness. The central aims of this writing are to outline the features of mental illness and examine the issues that surround the career development of those who have been affected.

Keywords: career development, disability, ICF domains, mental illness, psychological disorder, rehabilitation, residual symptoms, stigma, supported education/employment

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Introduction

The following is an excerpt from an interaction with a 28 year old young man who was pursuing a bachelor's degree in engineering when he was first affected by schizophrenia (Arulmani, 2006). His active symptoms had subsided and as was the norm, he had been sent for "occupational rehabilitation." But within a week he refused to go to the rehabilitation center. Initially, this refusal was attributed to his illness, a relapse was feared and the psychiatrists began to consider increasing his medication. Closer engagement with him led him to say, "Look, I had dreamed all my life of becoming an engineer. I was enrolled in a great college and then I fell ill. Okay, maybe that is fate. But this rehabilitation is worse! I am expected to go every day to the occupation center and make candles! Or if not that, paper envelops! Look, I don't need rehabilitation. Everyone thinks I'm mad. I'm not mad. *I don't want to make candles.* I just want to complete my course and become an engineer." While at one level this statement maybe touching and poignant, at another level, it is a vivid and stark representation of the disempowerment suffered by a person recovering from mental illness. Such disempowerment can incapacitate the individual personally, socially, and professionally.

The World Health Organization's (WHO, 2004) report on global mental health presented the following startling findings: Mental, neurological, and substance-use disorders (MNS) contribute to 13% of the global burden of disease, exceeding both cardiovascular disease and cancer; the third leading contributor to the global disease burden is depression; and by 2020, 30 million will have attempted suicide. It is also known that despite being willing to work and having the appropriate educational qualifications, a large preponderance of those with psychiatric difficulties do not have long-term success in the labor market (e.g., McReynolds & Garske, 2003). Using data collected over 10 years from an inner London borough, Perkins and Rinaldi (2002) reported that those with long-term mental health

problems suffered increasing rates of unemployment in the 1990s. Although during this period, employment for the general majority of the population increased, *unemployment* rates of the mentally ill increased from 80% to 92%. In a study by the Banyan Academy of Leadership in Mental Health (BALM) in India, mental illness was cited as one of the main reasons for not working and the average duration of illness was higher among non-workers (BALM, 2012). These rates of unemployment are disproportionately high not only in comparison to the general population but also in comparison to other disabilities (World Bank, 2007). Surveys and reviews have consistently indicated that paid employment helps the person affected by mental illness to return to normal functioning, brings personal meaning back into his/her life, fosters pride, boosts self-esteem, and also teaches effective coping strategies (Dunn, Wewiorski, & Rogers, 2008). Of relevance to the discipline of career counseling is the finding that high unemployment rates amongst the mentally ill are related to the absence of effective vocational support and career guidance services (e.g., Resnick, Rosenheck, & Drebing, 2006).

Against this background, this chapter has two central objectives. The first is to provide information about mental illness with a view to helping the career guidance practitioner understand potential clients who have been affected by mental illness better. The second objective is to examine how career guidance and counseling can support those who are recovering from mental illness such that the all-important goal of *sustained* employment does not remain elusive for them. This chapter is also useful for mental health professionals who are otherwise not specialists in career guidance and counseling (e.g., psychiatrists). The content is valuable for building their sensitivity to and clarity about the career-related challenges faced by a person recovering from mental illness.

Understanding the Signs and Symptoms of Mental Illness

Our understanding and acceptance of mental illness has been strangely different from other ailments and a peculiar association has existed between mental illness and metaphysical/spiritual interpretations. Conceptions of “madness” in the Middle Ages in Europe were a mixture of the divine, diabolical, and magical. In fact, the term “lunatic” has its roots in Roman mythology: “moonstruck” by the goddess Luna. A deep-rooted belief emerged (and continues to persist in many cultures) that the mind and body of the mentally ill person has somehow been tampered with and tainted by “evil” forces. Today, of course, there is a deeper understanding of the risk factors, symptoms, and outcomes of this group of human ailments. Unfortunately definitions of mental illnesses remain vague and noncommittal.

The behavior of the mentally ill person can be quite misunderstood. Therefore, we briefly describe the primary signs and symptoms of mental illness. Specific information about the symptoms of mental illnesses is presented in Table 1 as classified by the International Classification of Diseases, Version 10 (ICD-10) (WHO, 1992). It must, of course, be kept in mind that many of the symptoms described are not always signs of mental illness as many people who do not have a mental disorder experience them also. They can be considered as symptoms of mental illness only if they are associated with change in functioning and behavior and/or cause distress to self and/or to others.

Insert Table 1 about here.

Knowing the diagnostic category the person belongs to (i.e. does the person have schizophrenia, anxiety disorder, or phobia?) is not as important for the career counselor as understanding how the symptoms could impact the person’s work life. We have, therefore, attempted in Table 1 to link key symptoms of specific mental illnesses with the manner in which they can affect the individual’s work life. We now lay out a few points that could help

the career counselor understand these symptoms and the implications they have for career counseling.

Symptom Intensity and the Notion of a Continuum

Earlier understandings of psychopathology categorized all mental illnesses into two broad categories: psychoses and neuroses. Psychoses (e.g., organic psychoses, schizophrenia, and mania) were described to be severe and debilitating mental illnesses. Neuroses (e.g., phobia, anxiety disorder) were described to be less debilitating and, therefore, less severe. Today, the classification of mental illness has moved away from dichotomous, mutually exclusive categorizations. The contemporary understanding is that symptoms lie along a continuum of severity and intensity (e.g., Johns & van Os, 2001). The key indicators that are still in use, however, are: the extent to which symptoms impair the individual's ability to distinguish between subjective experience and reality; the insight the individual has into the symptom; the individual's connectedness with reality. The terms *mild*, *moderate*, and *severe* are commonly used to describe different levels of mental health problems (National Institute for Health and Clinical Excellence, 2011). The term *common mental disorders* is also used based on the wider prevalence of certain illness (e.g., depression, generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and phobias).

To understand how symptom intensity affects the professional life of those suffering from mental disorders. Let us take the example of the anxiety experienced by three individuals having to make a formal presentation to clients at work. The experience of anxiety for one person maybe such that it motivates and pushes him/her to prepare well for the presentation. Anxiety may cause the other person to fumble through the presentation, but still complete it successfully. The third person's experience of anxiety for the same task maybe so intense that it is debilitating, causing great distress, and detrimentally affecting

performance. It is the third person who would be described as suffering from anxiety disorder. And it is when such a person makes an appearance in a career counseling center that attention must be paid to the manner in which the symptoms of anxiety disorder could affect his or her career development. This is discussed in greater detail later in the chapter.

Symptom Impact and Recovery

The symptoms of severe mental illnesses can be profoundly disabling and recovery can be painfully slow. It is most important for the career counselor to note that the impact of mental illness on the person's motivation, ability to persist with the tasks of daily life, and the ability to work can be significant. The onset of the symptoms could be acute and their intensity such that the individual loses control of self, of the manner of interacting with others, as well of professional tasks and duties. The individual's behavior could be so bizarre, that it could affect others' perception of the individual. For example, when a person is symptomatic and suffering from paranoid delusions, a colleague could be viewed with suspicion and even be accused of hatching a conspiracy to spoil chances of promotion. The person at the receiving end of these accusations would, of course not, understand the deep psychological processes underlying the paranoid ideation. Hence, the relationship could suffer severe damage and even after recovery, the colleague may continue to view the individual in the light of his or her behavior during the symptomatic period. Hence, while the symptoms themselves are debilitating, the social fallout of the manifestation of these symptoms could profoundly influence the affected person's reintegration into the world of work. Box 1 presents excerpts from case notes that illustrate the bewilderment and loss of trust experienced by colleagues and the shame and loss of confidence experienced by the affected person. Drawing the person back into the world of work requires the skills to manage the impact of the person's symptomatic behavior on the work context of which he or she was a part.

Insert Box 1 about here.

Residual Symptoms: A Waxing and Waning Course

Mental disorders are unlike chronic physical illness in their course and outcome. Diabetes and such illnesses, for example, can be well controlled if the prescribed regimen of medication and diet is followed. Treatments for most mental disorders are effective but for a substantial proportion of individuals, only partially so. With some mental disorders, symptoms are known to persist in a residual form after the acute phase of the illness is over. In the case of depression, for example, symptoms such as low mood, disturbed sleep, disturbed appetite, tiredness, and irritability have been found to persist subclinically, even a year after the acute phase (e.g., Mojtabai, 2001). Hallucinations and delusions that afflict persons with schizophrenia may not interfere significantly with their daily life after the acute phase, but can persist at a diminished level of intensity causing their behavior to be odd and strange. The same is the case with the less severe, common mental disorders as well. The case notes presented in Box 1 offer examples of residual symptoms and how they affect reintegration into work roles. Symptoms of mental disorder are reactive not only to internal biochemical changes but also to psychosocial factors. Hence, a vital point that the career counselor must note is that most symptoms will have a *waxing* and *waning* course. At the same time, there is clear research evidence that symptoms are much better controlled and recovery is stronger when the individual is connected to his or her community and to meaningful work roles (Bond & Campbell, 2004). The implications of this for career development are significant. When symptoms flare up, the individual may be so incapacitated that his/her work performance suffers. At the same time, abruptly dropping out of work would impair the possibility of re-entry. Supporting the career development of those recovering from mental illness requires the career counselor to know how to support career development through the waxing and waning of symptoms.

Drug Side-Effects

The drugs available today have given people with mental illnesses better chances than ever before to live satisfying lives. At the same time, each of these drugs can cause side-effects. The type of side-effect and its intensity would vary across drugs and individuals. Sometimes, other drugs have to be taken to reduce the side-effects of the primary medications. Many of these side-effects affect the person's work performance. This in turn could set off a vicious spiral of frustration, irritation, and loss of motivation. The desire and need to get back to work could even cause the affected person to discontinue medication. These are critical issues that the career counselor must be aware of in order to support the individual's sustained reintegration into the world of work. The U.S. Department of Health and Human Services (2012) provides a comprehensive overview of the side effects of mental health medications and is a useful resource.

When Does the Career Counselor Become Relevant?

The relevance of career counseling is closely related to whether the affected person can engage with the counselor. The discussions so far allow us to make the following observations regarding the symptoms of mental illness.

Quality of symptom manifestation. The quality of symptom manifestation could be at various levels. When yet to be treated, symptoms are florid and the individual is experiencing high levels of distress: the *acute phase* of the illness. At another level, treatment may have begun and symptoms may have started decreasing in intensity. The individual's distress maybe lower and the individual's insight into and personal control over the illness maybe increasing: the *treatment/recovery phase* of the illness. This is also a time, when the side-effects of medication could emerge.

Nature and extent of recovery. Recovery from mental illness is a slow process and the course of recovery could fluctuate. In many cases, residual symptoms could persist much

after the acute phase. It is also to be expected that the illness has caused significant personality changes in the individual. The extent of recovery therefore cannot be easily predicted. At one end of the recovery continuum are those who may be so badly affected that they require continued custodial care and a sheltered environment. At the other end are those who have returned to earlier levels of functioning and can be gainfully employed. The majority, however, would lie at neither of these extremes. In most cases, symptoms wax and wane, in some situations slipping far back to almost the acute phase and in other situations making slow and steady progress toward normalcy.

The point of intervention: Three key markers. The earlier the person's reconnection with the regular routines of life, the stronger and quicker will be the recovery. Hence, creating opportunities for meaningful work is relevant at all stages of recovery from mental illness. This is true also for those whose recovery has not moved much beyond custodial care. On the other hand, it must be noted that when symptoms are flagrant and the affected person is in severe distress career counseling may not be effective or appropriate. For example, if the person is at a stage where his or her thoughts and actions are controlled by delusions and he or she is unyielding to counterargument, the person may not be ready for career counseling. Three key markers may be kept in mind when making an assessment of whether career counseling would be relevant and contribute to the recovery process:

- the individual's ability to distinguish between subjective experience and reality
- the quality of insight the individual has into his or her situation
- the quality of the individual's connectedness with reality

Understanding Disability that is Caused by Mental Illness

Unlike other disabilities such as locomotor disability or blindness, disabilities that are caused by mental illness such as apathy, difficulty with concentration, amotivation, communication difficulties, and poor interpersonal skills are not visible. Hence, it may even

be difficult for the lay person to accept that the person suffering or recovering from mental illness is disabled in any way. There are instances when disability benefits like bus passes have been denied because these individuals look physically strong (Chandrashekar, Kasthuri, Kumar, & Prashanth, 2010). This is further compounded by the stigma attached to mental illness and the discrimination that follows as a result (Murthy, 2005; Wig, 1997). It is important therefore that the career counselor orients him/herself to contemporary understandings of disability.

What is Disability?

Until about two decades ago, health and disability were viewed dichotomously: disability began where health ended. The disabled were segregated and the medical model was used to understand and support their needs. Since the 1970s, stronger emphasis has been laid on community and educational inclusion. The WHO (2002) has asserted, for example, that the objective is to understand the individual's functioning in society, irrespective of the person's impairments. Today, a comprehensive *biopsychosocial* model is used to understand and describe disability (e.g., The International Classification of Functioning, Disability and Health [ICF]) (WHO, 2001a, 2002), which may be physical, cognitive, mental, sensory, emotional, developmental, or some combination of these. The ICF does not make a distinction between the type and cause of disability, for instance, between "physical" and "mental" health. Disability is conceptualized on a continuum from minimal difficulties in functioning, to impacts that have major effects on a person's life. Within this conceptualization of disability, the ICF (WHO, 2002) categorizes difficulties in human functioning into three interconnected areas:

- Impairments: problems originating from body functions or alterations in body structure (e.g., loss of control over limbs due to paralysis).

- Activity limitations: difficulties in executing activities (e.g., difficulties in commuting to the workplace).
- Participation restrictions: difficulties with involvement in any area of regular life (e.g., facing discrimination in employment).

As per this framework, disability arises from complications faced in any or all of these three areas of functioning. The preamble to the Convention on the Rights of Persons with Disabilities (CRPD) (Committee on the Rights of Persons with Disabilities, 2006) highlights that, “disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others” (p. 1). Placing disability within an interactionist framework implies that disability is not an attribute of the person. It is the interaction between health conditions and contextual factors, namely environmental and personal factors, that results in disability.

Disabilities that the Mentally Ill Experience

Thara and Tharoor (2012) have identified four general areas in which disability that is caused by mental illness can manifest:

Activities of daily living. These include day-to-day adaptive activities such as cleaning, shopping, cooking, transporting oneself, maintaining a home, self-care, using public facilities, and other such routine, yet essential activities.

Social functioning: Relationships. This refers to the individual’s capacity to interact appropriately and effectively with other individuals. Social functioning includes the ability to get along with others in one’s environment. Impaired social functioning may be demonstrated by a history of altercations, evictions, fear of strangers, avoidance of social occasions and interpersonal relationships, and social isolation.

Cognitive functions: Attention and concentration. The ability to manage concentration, task persistence, and pace may be affected. Particularly debilitating can be the

decreased ability to sustain focused attention sufficiently long enough to permit the completion of tasks commonly found in work settings.

Work life. Deterioration or decompensation in work or work-like situations refers to the repeated failure to adapt to stressful circumstances which cause the individual either to withdraw from the situation or experience subjective distress and an exacerbation of symptoms. There could be an accompanying difficulty in maintaining activities of daily living, social relationships, and/or maintaining concentration and task persistence.

Stigma: Disabled by Society

Social stigma refers to the expression of strong disapproval and displeasure towards a person on the basis of some personal feature that differentiates him or her from other individuals in the group. Stigma attached to mental illness has been extensively studied and it is clear that it is a complex and deep-rooted combination of feelings, attitudes, and behaviors (Penn & Martin, 1998). The World Health Report on Mental Health (WHO, 2001b) unequivocally states that the “single most important barrier to overcome in the community, is the stigma and associated discrimination towards persons suffering from mental and behavioral disorders” (p. 108). Goffman (1963) has pointed out that mental illness, hits directly at the person’s identity and pushes him or her away from the realms of normalcy to be labeled and perceived as “abnormal.” Stigma can become a part of the group’s social structure and result in tangible barriers being placed before the affected person. For example, in many legal systems, people who have been diagnosed with a mental illness are not allowed to participate in the electoral process, hold certain offices, enjoy child custody rights, drive a car, hold certain occupational posts, and sign legal documents (e.g., Ratanlal, 2002). When the entire social structure directs stigma toward the affected individual, it is very likely that the individual would succumb and would judge self as wanting. Corrigan (2004) has described self-stigma as “a private shame that diminishes self-

esteem and causes self-doubt regarding whether one can live independently, hold a job, earn a livelihood, and find a life mate” (p. 620).

More than the disabilities that result from mental illness, stigma causes prolonged periods of unemployment. This increases the affected person’s difficulties to re-enter the labor market which in turn leads to social decline. The best of career counseling efforts can fail if the dynamics between stigma and mental illness are not understood. As will be discussed further ahead, career counseling can make a significant contribution to arresting this stigma-induced decline.

Assessing Disability Related to Mental Illness

The meaning of recovery is hard to define for mental illness. Most persons who have suffered mental illness recover from the acute phase of their symptom manifestation with treatment and rehabilitation. To what extent they recover and how long they remain symptom-free varies from one individual to another and across mental disorders.

There is research to support that many mentally ill persons can return to a level of effective functioning socially, and at work, and contribute significantly to the life of the larger community. Some can remain free of symptoms, without medication. It is against this background that methods of assessing psychiatric disability have been designed. Being able to assess a client for the extent of disability caused by mental illness is a critical skill that the career counselor must develop.

Approach to the Assessment of Disability

Two approaches could be taken to plan career development interventions. One way is to base one’s starting point on the diagnostic category to which the affected person has been allocated. This implies that one would plan an approach for persons with schizophrenia, a different one for those with anxiety disorder, another one for those diagnosed with a phobic disorder, and so on for each diagnostic category. As pointed out in the World Health Report

(WHO, 2011), couched within such an approach is the assumption that each type of disorder has specific health, educational, rehabilitation, social, and support needs. In the second approach, the target is to obtain a clear view of the affected person's disabilities and impairments and develop career development plans based on this understanding. The next section introduces the reader to a well-known assessment schedule that follows a functions based approach to the assessment of disability.

The International Classification of Functioning, Disability and Health (ICF)

The ICF is the conceptual framework created by the WHO within which health and disability can be defined, measured, and understood (WHO, 2001a, 2001b). The ICF is particularly relevant when supporting the career development of those affected by mental illness because it helps the counselor understand the person's level of capacity: what he or she *can do* in a standard environment. It also provides a framework for understanding the client's present level of performance: what he or she *presently does* in the existing environment. The ICF therefore emphasizes functioning, rather than disability by shifting focus from a preoccupation with causes to the impact the illness or disability has on the individual. The ICF makes an observation that is critical when planning career development interventions for those recovering from mental illness: A diagnosis, or the recognition of the presence of an illness, does not always predict work performance, the potential of returning to productive work, and the quality of reintegration into social roles. What is required when designing a career development program is data pertaining to the levels of functioning and disability. The ICF offers a systematic and internationally applicable method of collecting this crucial data. We will in the following paragraphs present information about the ICF that illustrate its relevance to the practice of career guidance for psychologically affected persons. However, these are only abbreviated illustrations and the interested reader is advised to go to the original ICF documents for a more complete picture (WHO, 2001a, 2002).

ICF Domains

The ICF classifies areas of life into three domains:

Body function and structures. This domain refers to the individual's *physiological* and *psychological* functions. The focus is not on causes but on the function itself.

Fluctuating attention, for example, describes the quality of a psychological (cognitive) function that could be seen in schizophrenia, anxiety disorder, as well as phobic disorder. In this example, collecting more information about the individual's ability to pay attention would be the target for the counselor who is planning a program to re-integrate the affected person into the world of work. The ICF offers standardized formats through which functional abilities and impairments linked to eight body functions could be recorded in very specific detail.

Activities and participation. Within this domain, the focus is on the individual's functioning as a whole person.

Activity is related to the performance of a task or action by the person. Activity Limitations are problems the person may have in executing certain tasks. Becoming unable to leave home because of overpowering anxiety is an example of an activity limitation.

Participation describes the person's quality of involvement in a life situation. Participation Restrictions are difficulties the person may experience in connecting with and contributing to life situations in the manner that he or she did before the onset of the illness. Take, for example, an accountant who has rejoined duty after suffering an attack of schizophrenia. He may be reinstated to his original post, but his colleagues/employer may not be sure anymore of the accuracy of his calculations. Hence, he may not be allowed to participate as vigorously as before with crucial aspects of his earlier work roles.

The ICF classifies activity and participation domains into nine categories as shown in Table 2 ranging from basic to complex levels. For the career counselor, information derived

from the ICF could provide invaluable information pertaining to the person's work-related functions.

Insert Table 2 around here

Environmental factors. The ICF recognizes that the physical, social, and attitudinal environment in which people live could be facilitative, or could become barriers. Hence, a significant emphasis is placed on the interface between the affected person's symptoms and contextual factors. Five categories of environmental factors are described in the ICF. Each category has a comprehensive listing of specific items. We provide illustrations below:

- Products and technology (e.g., architecture of buildings and access to a work place).
- The natural environment and human made changes to environment (e.g., the noise in the work location maybe such that it exacerbates a disability).
- Support and relationships (e.g., the manner in which people in positions of authority, such as an employer engage with the affected person).
- Attitudes (e.g., social attitudes toward the disability).
- Services, systems, and policies (e.g., sensitivity of labor policies to disabilities).

The ICF provides a 4-point-rating scheme by which each item could be examined for the extent to which it facilitates or creates a barrier. For example, a rating of 4 on the barrier side for labor and employment policies would mean that the affected person is living in an environment where no policy or legislation exists to help the person reintegrate into the world of work. Conversely, a rating of 4 on the facilitator side for the same item would mean that substantial support is available through legislation and policy for the person to reintegrate into the world of work. In this scheme, 0 indicates that the item is neither a barrier nor a facilitator. Information about environmental factors is of vital importance when planning a career development program for a mentally affected person. For example, it could be that the affected person's work location is a small, closed, windowless room. If one of the primary

symptoms that this individual suffers is a fear of closed spaces, going back to work in a windowless room would only worsen his or her disability and cause severe participation restrictions.

ICF Qualifiers

The next construct in the ICF scheme is Qualifiers which allows the assessor to note the occurrence and seriousness of a problem across the three domains: body, activity, and participation along a 5-point scale (no, mild, moderate, severe, and complete impairment). These constructs are illustrated in Table 2 and explained briefly here.

The performance qualifier. This qualifier reflects the affected person's functioning in his or her "current" environment and indicates the extent to which the person's performance is restricted. It is a measure of "involvement in a life situation and the lived experience of the person" (WHO, 2001a, p. 12). Most important for career guidance and counseling is that the performance qualifier provides a measure of the struggle the affected person experiences in his or her attempt to reintegrate.

The capacity qualifier. This is a description of the affected person's ability to perform on a task or execute an action. Accurate elicitation of information would reveal the affected person's "highest probable level of functioning in a given domain at a given moment" (WHO, 2001a, p. 13). Information obtained through this qualifier would help the career counselor understand the affected person's capacity relative to what would have been expected normally of that person before the onset of the mental illness condition.

The ICF provides a rating scale that ranges from 0 (*no difficulty*) to 4 (*complete difficulty*). The scoring scheme is detailed in Table 2. High scores on the performance qualifier indicate that performance restriction is high, that is, the environment is placing restrictions upon the person. On the other hand, high scores on the capacity qualifier indicate

that the person's capacity itself has been affected and hence his or her activity potential is low.

The ICF provides a list of questions designed to elicit information related to the performance and capacity dimensions for each of the items. These are general questions and are to be adapted as necessary during the course of the interview. For example, ICF questions for Major Life Areas (sub item: remunerative employment) are as follows:

- Questions related to performance: In your present surroundings, how much of a problem do you actually have getting done all the work you need to do for your job? Does your work environment and the way in which your tools are set up, make it harder for you to execute your work tasks? Is your capacity to do your job, without assistance, more or less than what you actually do in your present surroundings?
- Questions related to capacity: How much does your present state of health affect your ability to get done all the work you need to do for your job, without assistance? How does this compare with someone, just like yourself but without your health condition?

The environmental qualifier. The inclusion of environmental factors in the scheme makes it possible for the career counselor to better understand how contextual realities function as barriers and facilitators for both capacity and performance dimensions of actions and tasks related to work. Environmental factors include geographical features such as climate and terrain, characteristics of the work environment, social attitudes, institutions, and legal provisions. With such information in hand, practical plans could be made to support the functioning of the affected person at work.

The ICF is designed to measure disability emerging from all forms of illnesses and disorders. An example of using it to assess disability arising from mental illness is described in a later section. Similar approaches to the ICF have also been developed at the local level.

In the following section we provide an example from India as an illustration of what the career counselor could search for in case a locally validated measure is required.

The Indian Disability Evaluation and Assessment Scale (IDEAS)

IDEAS is a tool developed by the Indian Psychiatric Society (2002) to measure disability related to psychiatric illnesses. It has been gazetted by the government and is the officially recommended instrument to measure psychiatric disability in India. Certification based on IDEAS qualifies a person for government benefits and schemes that have been made available for the mentally ill.

IDEAS has four themes: self care, interpersonal activities (social relationships), communication and understanding, and work. As with the ICF, IDEAS also offers a framework to assess an individual keeping work and career development in mind. It could be used as a tool by the career counselor to plan the individual's reintegration into work. The work dimension addresses three areas: employment, housework, and education. Assessment of the individual's status on the work dimension includes employment seeking behavior and the ability to perform employment related tasks completely, efficiently and in proper time. At the level of performing housework, assessment includes the individual's ability to cook, care for others, belongings and household items. The work dimension also includes the individual's engagement with the educational system and covers activities related to school/college performance such as regularity of attendance, ability to meet educational targets, reading and retention of material, ability to pay adequate attention and prepare and succeed in examinations.

Links between Career Counseling and Disability Assessment

Instruments such as the ICF and IDEAS, if executed with sensitivity, allow the career counselor to determine the "gap" between the affected person's capacity and performance and the extent to which the specific aspect of his or her environment is a facilitator or a

barrier. An ICF assessment could reveal, for example, that capacity is less than performance. This would mean that the current environment is an enabling one, allowing and facilitating the affected person's performance. Most often the situation is the other way around: capacity is greater than performance. This indicates that barriers to performance exist in the affected person's environment blocking the manifestation of his or her capacities. Addressing this barrier, or preparing the person to deal with this barrier, would be a critical career development target.

The clues are in the gaps: A case example. With a view to demonstrating the links between career counseling and disability assessment, we now draw the reader's attention to a more detailed examination of information presented in Table 2. The table presents the ICF Activity and Performance Domains and has been scored based on an interview with a person diagnosed with anxiety disorder: a 39-year-old female accountant who referred herself for career counseling with the complaint that she was not able to do well at work and wanted to change her job (Arulmani, 2006). The person was interviewed using the ICF schedule. Let us briefly examine the ratings that were made for this individual and what these ratings mean for career counseling within the ICF scheme.

- *Speaking*, emerges as an item of particular relevance where the capacity qualifier score is higher than the performance qualifier score. The interview with this person revealed that she had a significant stammer which considerably worsened when her anxiety increased. This difficulty was rated as a *complete difficulty* (score of 4) since it was present more than 95% of the time, totally disrupting day-to-day life, particularly at work. On the performance qualifier side, the difficulty is only at the *mild* level (score of 1), since it restricted her performance less than 25% of the time and that any performance restriction only occurred rarely. This implies that she ought to have been able to tolerate the disability. Yet, her disability (capacity qualifier) was high.

- The ratings for *holding a conversation*, is also of relevance. Here, both the performance qualifiers and the capacity qualifiers are rated as *severe difficulty* (score of 3). The content of the interview revealed that this person's job role required her to make presentations to potential clients. This evoked a high level of anxiety in her and worsened her stammer as indicated by her high capacity qualifier score. On the performance side, her clients exhibited obvious signs of ridicule and displeasure. This aggravated her anxiety, increased her stammer, and so the vicious cycle spiraled, pulling her downwards. The final result was that on most occasions, she was not able to win confidence and lost clients. Here, although her immediate work environment (e.g., her employer, her colleagues) were supportive, persons external to her office were not as tolerant. Hence, her performance qualifier indicates performance restriction.
- Similar trends are seen for items under Interpersonal Interactions. While her difficulties at the level of *basic interpersonal interactions* are only at the *mild* level, discrepancies between performance and capacity become more complex. A particularly high discrepancy is seen in *relating with strangers* and *intimate relationships*.
- The culmination of these difficulties is seen in *remunerative employment*, where the rating is at the level of *severe difficulty*. This implies that her employment could be at risk.

Planning career development based on a functions oriented assessment. The case example presented demonstrates how a functions-oriented assessment schedule could generate data, based on which a career development plan could be formulated. The person came to the career counselor with the complaint that she was not able to do well at work and wanted to change her job. The information gleaned and the ratings made point to developing a strategy that is focused primarily on the person and certain aspects of her work environment. The assessment indicates that although changing her job was what the client

wanted, it was most likely that she would have encountered similar if not worse difficulties in another job as well. What she would benefit from is an intervention that would first of all address her anxiety and her difficulties with speech. Hence, the career counselor's target here was twofold. The first was to refer her to a specialist with the expertise to deal with her anxiety difficulties (e.g., a clinical psychologist) and/or a specialist with expertise to deal with stammering (e.g., speech therapist). The specific career counseling objective would be to mitigate the impact of her psychological difficulties on her work performance, rather than consider a change of job. The career counseling that she was provided is described briefly below:

- The career counselor, first of all, used the data obtained to point out to her that her immediate work environment (employer and colleagues) were exceptionally supportive. The job roles at which she was successful (e.g., solving problems, undertaking multiple tasks) were delineated to highlight her *well-functioning* areas, rather than her difficulties.
- Her attention was drawn to the possibility that roles which required her to engage with people external to her company (e.g., potential clients) worsened her condition and thereby affected her work performance.
- The career counselor then worked with this person to list in detail, the specific components of her job role. Roles that were directly linked to her disability were identified. For example, client facing duties particularly when her clients were strangers emerged as a job role that significantly affected her work performance.
- Based on this information the career counselor prepared a referral note for her to present to the other therapist she was going to see.

- She was also encouraged to communicate with her employer, requesting to be relieved of duties that brought her disabilities to the fore. At the same time, she listed other duties she could take up instead.
- Follow-up after 6 months indicated that the approach had been successful. Her employer had taken her off duties that worsened her condition and replaced this with other duties. This in turn caused an immediate reduction in her anxiety, boosted her confidence, and her work improved remarkably. She had enrolled for therapy with a clinical psychologist and was gradually gaining control over her anxiety which in turn was improving her speech difficulties. Her final comment (with only a minimal stammer!) throws clear light on how career counseling helped her. She said, “I moved from a down cycle to an up cycle because career counseling showed me what I should *avoid* at work!”

This case example illustrates career counseling from the capacity qualifier side. There could be other instances where the career development plan may have to focus on the performance qualifier side, with greater emphasis being laid on environmental and contextual matters. Other individuals may require support both with their performance as well as their capacity. The point being made is that a careful assessment of activity and performance domains offers a strong, person-centered platform upon which to plan a career development program relevant to the needs of a person with psychological difficulties.

Integrating Disability Schedules with Career Services

We now list the skills that the counselor could develop in order to integrate information from disability schedules with career counseling.

- A critical skill is that of *elicitation*. Using tools such as the ICF, the career counselor is required to draw out as much information as possible with regard to the disability, along with its performance and capacity dimensions. The score given is not as

important as the content of the interview and quality of responses that the counselor is able to elicit, keeping in mind the ultimate target of reintegration into work.

- Next is the skill of *delineation*. The plethora of difficulties elicited might seem overwhelming. The task before the career counselor now is to select from the information elicited, issues that belong in the realm of career counseling and those which need the expertise of other specialists.
- Another skill that the career counselor must acquire, particularly when working with the mentally ill, is the skill of *referral*. As illustrated in the case example described, the career counselor clearly identified targets that could be achieved through career counseling and referred the client to professionals for help with her other difficulties. It is essential that the career counselor working with those recovering from mental illness, expands his or her referral network and develops professional relationships with other mental health professionals such as clinical psychologists, psychiatric social workers, psychiatrists, and psychiatric nurses.
- Another career counseling skill, is that of *making links between* the difficulties that have been identified. In the case example presented, the counselor made the links between: a desire for job change, anxiety, failure at certain job roles, and stammering. Identifying these linkages allowed the counselor to facilitate the breaking of the negative cycle that had gripped the client.

Supported Education and Supported Employment

One of the criticisms leveled against vocational rehabilitation models is that they excessively focus on prevocational skills and simulate work environments that have no real connection with career development (e.g., Hirsch, 1989). Some of the latest reviews of outcomes, for example, indicate that “sheltering” those with psychiatric disabilities is less effective than exposing them to the real world as quickly as possible (e.g., Cimera, Wehman,

West, & Burgess, 2012). The challenge before the career counselor, therefore, is to move the person toward competitive and meaningful employment. We present below, two salient themes emerging from the literature that have direct relevance to the practice of career counseling for the mentally ill.

Supported Education

Epidemiological surveys in different countries have shown that ailments related to the mind begin very early in life. Kessler et al. (2007) based on a comprehensive review of the literature stated, for example, that, "Half of all lifetime cases begin by age 14; three quarters have begun by age 24. Anxiety disorders often begin in late childhood, mood disorders in late adolescence, and substance abuse in the early 20's" (p. 2). This is exactly the period when the building blocks of the individual's career development, namely, educational qualifications are being laid. The onset of mental illness during late adolescence-young adulthood prevents many of these individuals from completing their education and obtaining qualifications to find suitable employment. Without appropriate education these individual can be severely disadvantaged in pursuing employment goals. Furthermore, the rather mediocre success levels of vocational rehabilitation programs has been linked to the absence of postsecondary education and training amongst those recovering from mental illness (e.g., McQuilken et al., 2003).

Supported education which emerged in the early 1990s in the United States and Canada, is an approach to educational programing that assists people with psychiatric disabilities in their pursuit of further education. Keeping in mind their psychological difficulties, supported education for these individuals is planned and paced according to their present level of functioning and the disabilities caused by the mental illness. Supported education programs, are *in vivo* assistance extended to affected persons and are aimed at strengthening or restoring educational competencies while avoiding segregated classrooms

(Mowbray, Collins, & Bybee, 1999). The avoidance of segregation is a key therapeutic point. Rather than sheltering the affected person from the competitiveness of a regular classroom, supported education exposes him or her to the real world. Hence, affected persons enroll for a course and then receive special attention in the form of supported education.

Evaluations of supported education programs have indicated that they have positive outcomes. Cook and Solomon (1993), for example, have reported that those who went through a supported education program to complete higher secondary education went on to enroll in college for further education. Hoffman and Mastrianni (1993) reported increases in competitive employment after the person went through supported education. Improvements in self-esteem and mastery have also been noted (Leonard & Bruer, 2007; Wolf & DiPietro, 1992).

Supported Employment

Supported employment emerged in the late 1980s as a response to the not-optimal outcomes of the sheltered workshop approach to rehabilitation. Skills that were learned in sheltered workshops did not effectively translate into competitive employment and the majority became dependent on government subsidies (Hirsch, 1989). Hence, the notion of supported employment emerged as paid, competitive employment that, although requiring ongoing support, would occur in integrated work settings (Wehman & Kregel, 1995). This stands in contrast to traditional vocational rehabilitation programs which focus on skills training preparation, sheltered workshops, and transitional employment. Revell, West, and Cheng (1988) have provided a description of the components of supported employment programs which are: conduct community-based assessments to obtain a person-job match, design relevant skill training to facilitate job development, offer placement services, and job site training. Supported employment also facilitates the identification and arrangement of

natural supports both on and away from the work setting. The model recognizes that integral to the individual's employment success is the provision of support services such that the affected person achieves long-term stability in employment. At the same time, while support services are integral to this model, the interventions are designed to ensure that over a period of time, a systematic reduction (fading) of on-site staff assistance is achieved. Supported employment stands in contrast to traditional vocational rehabilitation programs since it avoids a long period of preparatory work activities which are often disconnected from real-world requirements (Bond & Campbell, 2004).

Corrigan and McCracken (2005) refer to the traditional method of reintegration as "train-place." People recovering from psychiatric illness are first trained and then when recovery has been achieved, they are placed in real-world jobs. The supported employment paradigm takes the "place-train" approach and focuses on ensuring reconnection with the real world of work as quickly as possible. Hence rapid placement of people with disabilities is the first target. This is followed by in vivo support, resources, and training designed to ensure that the person successfully retains his or her position in the world of work. The therapeutic objective here is that the recovering individual is brought as quickly as possible to face the realities of real-world employment. The individual is shielded from the ignominy of skills retraining which anticipates defeat rather than success, reflecting indeed, the plea made by the young engineering student in the example cited at the beginning of the chapter: "I don't want to make candles!"

Bond, McGrew, and Fekette (1995) reported that 59% of participants in a supported employment program successfully entered competitive employment in comparison with 29% from a traditional vocational rehabilitation program. Another critical finding is that the pressures of re-entering the world of work did not increase symptoms and the risk of rehospitalization amongst those who had taken up professional work roles through supported

employment (e.g., Becker & Drake, 2003). Beyer (2007), using data from North Lanarkshire (UK), reported that employment rates improved and people were financially better off after obtaining a job through a supported employment program. Kregel (2012), reviewing a specific supported employment program in the United States (Work Incentives Planning and Assistance Program, WIPA), found that these individuals were more likely than others to have reached a position of employment security and could go off on welfare benefits. The Western literature is replete with such examples of the positive outcomes of supported employment.

Supported Education and Employment: Extensions across Cultures and Contexts

This section presents ideas on how these techniques could be adapted for career counseling and extended across varied cultures and contexts.

Initiate Support Facilities

Given the successful outcomes that have been reported in research, an obvious career counseling function could be to initiate supported education/employment facilities in situations where they do not exist. However, a point we would like the reader to note is that the initiatives described are from the Western world. The career counselor who intends to facilitate the establishment of such services in other cultures would do well to keep the following in mind:

Educate stakeholders. While the potential power of the supported education/employment is clear, it is also clear that a number of locally operating social and cultural factors could affect their implementation. Social stigma could be a significant barrier. The obvious point that emerges is that key persons must first be oriented and educated regarding the fundamental requirements of supported education/employment programs. This becomes an essential requirement in countries where there is no legislation or existing framework pertaining to the rehabilitation of the mentally disabled. It has been

shown, for example, that relapse is significantly reduced when the family is included as part of the treatment team (e.g., Dixon, 2001; Richmond Fellowship Society, 2012). In similar manner, when institutions (e.g., schools, places of work) are first oriented, the success of the initiative is more likely. This orientation would include providing information about the nature of mental illness and then creating provisions specific to the supported education/employment framework. It is also essential that all parties involved are informed about any medications the client is taking and the impact side effects could have on performance. MacDonald-Wilson, Rogers, Massaro, Lyass, and Crean (2002) have highlighted certain critical accommodations that would need to be made: flexible scheduling, job modification, facilitating communication on the job, modifying training methods, sensitizing personnel within the institution, modifying the physical environment, or allowing the individual to bring and use his or her special equipment. At the practical, day-to-day level, simple changes could make a world of a difference. This could include providing instructions in writing rather than verbally, creating schedules that allow for regular routines, reducing interruptions, and ensuring that the environment is not noisy.

Create incentives. An interesting recommendation made by the Banyan Academy of Leadership in Mental Health based on their field experience in India is to create incentives for potential employers. They suggest that jobs are created in organizations against clear cut vacancies, and not merely to meet corporate social responsibilities. They further suggest that tax benefits are offered to companies that employ persons with mental health issues (BALM, 2012).

Reposition career development. The traditional understanding of healthy career development is that the individual stays in employment, performing in such a way that he or she is moving steadily from one level to another. The career counselor working with the mentally ill must acknowledge that this may not be possible for those who suffer from

psychiatric ailments. One of the criticisms leveled against those with psychiatric ailments is that they do not stay on in employment. Keeping the person at the heart of the process, a new way of viewing employment would be to consider opportunities that allow for exits and reentries, aiming ultimately for the frequency of this fluctuation to reduce over time. This implies that the career counselor must strive to place clients in settings where they are likely to be successful without posing exceptional hardships on the employer (Caporoso & Kiselica, 2004).

Deploy Career Guidance and Counseling

The supported education/employment model offers a useful framework to deploy career guidance and counseling services. However, our review of the literature revealed that very little career guidance or counseling seems to be on offer for individuals with mental health difficulties. This is particularly so when they are planning to reenter education. Enrolling for education seems to be the primary motivation, rather than enrolling for education with a broader career development plan in place. We report here a significant study conducted by Getzel, Briel, and Kregel (2000), which articulates the link between career counseling and supported education/employment programs. Getzel et al. have identified some career development barriers that the mentally ill face despite being in supported education/employment programs:

- lack of information about self: personal interests, aptitudes and talents, as well as of personal disabilities resulting from the illness;
- lack of needed information about available careers;
- lack of work-experience opportunities, networking skills, and job-seeking skills;
- poor knowledge about how to identify suitable educational/occupational possibilities;
- lack of orientation with regard to the manner in which requests for modifications and accommodations from an educational institution/employer can be made.

Szymanski and Vancollins (2003) highlighted that poor preparedness severely compromises the person's career development after he/she has been placed in an educational/work role. Therefore, a vital contribution that career counseling could make is to help the individual understand his or her interests and talents, understand the world of work, identify possible career alternatives, and then plan for an education that would actually realize these possibilities. Here again, the career counselor must keep some of the characteristics specific to this client group in mind.

Adapt standardized assessment procedures. If the career counselor uses inventories, tests, and other psychometric devices for assessing the individual, he or she must be aware that the standardized administration procedures required by these tests may not be applicable when working with the recovering mentally ill person. The entire purpose would be defeated if the counselor draws conclusions about a person's aptitudes based on a timed test if the individual's symptom profile affects his/her speed of performance. Similarly, relying on standardized norms to interpret test results may not yield accurate results given the fact that it is most likely that this client group does not any longer fall into the normative sample upon which the test was constructed. Arulmani (see Chapter 34, this Handbook) has described a non-standardized, intra-individual approach that could be considered. In summary, tests that require timed administration are to be avoided and assessment should move at the test taker's pace. High emphasis is to be laid on the individual's hobbies and accomplishments, however small they may have been. Data is to be collected both from the individual as well as significant others (e.g., parents, siblings, friends). The individual's potential profile is to be constructed based on *intrapersonal* features, rather than on a comparison with a normative sample.

Help the person set realistic expectations. Lundin (2005) diagnosed at the age of 23 years with a schizoaffective disorder, looks back on his career development, and says in an

editorial that he was invited to write, “Over the years of my illness I had been bedeviled by unrealistic career goals...becoming a diplomat, famous politician, a famous actor...With the administration of anti-psychotic medicine, I gradually settled on applying myself to an entry-level position with skills I had available” (p. 2). As this quotation indicates, the individual’s expectation of recovery might be that he or she will continue from where he or she was before the onset of the illness. If it is the case that these capacities are presently still recovering, moving back to similar work tasks may accentuate the person’s limitations and hence increase the chances of failure. It is important of course to be sensitive such that when bringing disabilities into the recovering individual’s awareness he or she is not demotivated but rather becomes more mindful of potential pitfalls.

Facilitate self-mediated job matching. It has been pointed out that the placement of an individual in supported employment may be a decision made by the rehabilitation practitioner rather than the individual (Hirsch, 1989). It is vital that the career counselor teaches a client how to choose his/her job. This would facilitate the person’s involvement in the process and cause him or her to take personal responsibility. This exercise would also include teaching the individual that merely making a choice need not mean that one will obtain the job one desires. Learning to plan for career alternatives, and being prepared to accept the closest match are all aspects of recovery that the career counselor is optimally positioned to facilitate.

Optimize the person’s engagement with the real world. Going back to school or to work is a significant step toward rejoining the mainstream of life. This goes beyond the teaching and learning that occurs in the classroom or the execution of tasks in the workplace. It allows the person to be absorbed into social activities that facilitate normalization. Opportunities to be engaged in sports, cultural activities, recreation, and leisure abound in educational/employment settings. For example, the simple activity of going to the canteen

for a meal or a coffee *with everyone else* would itself begin to draw the person away from his or her “abnormal” persona. These opportunities could be missed if they are not actively facilitated and this is a role that could be sensitively played by the career counselor.

Promote the person’s reclaiming of identity. Goffman (1963) noted that stigmatization resulted in “spoiling” the individual’s identity. Successfully enrolling for a supported education/employment program brings with it the prospect of affected persons reclaiming personal identity. The affected person could have acquired the identity of “sick person” or “strange” or “abnormal” person. Occupational identity emerges from the individual’s occupational trajectory. Mental illness dramatically interrupts this trajectory. Enrolling into an educational program or regaining work roles implies that the person has actually moved from being a “psychologically ill patient” to a “learning and growing student” or a “contributing worker.” Facilitating this insight is a career counseling function that would contribute significantly to the person’s redefinition of self, the cornerstone of the new edifice of life that the person is attempting to reconstruct.

Be prepared for ongoing, long term follow up. Caporoso and Kiselica (2004) have reminded us that the counselor who is interested in supporting the mentally ill must keep in mind that placing the person in a job does not signal the end of the career counseling. Central to long-term follow-up is the battle with stigma. While the broader systemic objective is to change the mindsets of the stigma holders, the career counseling objective is to empower the person recovering from mental illness to battle through the stigma. An important long-term requirement, after the client begins supported education/employment, is to keep him or her reminded of strengths and limitations and their potential impact on performance. This would include helping the client deal with symptoms, side-effects of medication, and conflicts that could arise at work or at home. Beginning a support group comprising individuals who are enrolled in supported education/employment is known to be an effective device for long-term

follow-up (Caporoso & Kiselica, 2004). At one level, it reduces the burden on the career counselor. At another level, it creates a network of people with similar difficulties who could encourage and help each other.

New Concepts and Viewpoints: Charting New Directions

Most of the disabilities suffered by the mentally ill are in the cognitive and emotional realms of functioning. These disabilities cannot be easily understood by others, and hence the management of these disabilities requires considerations that are different from other illnesses. An important viewpoint for the future for career counseling is that the focus is not on what the person cannot do but instead on the person's functional attributes. This critical requirement was highlighted at an important seminar held in India entitled: Employment towards Empowerment for Persons with Mental Health Issues: Challenges and Prospects (BALM, 2012). In addition to the points made throughout this writing, we draw upon the salient recommendations of this seminar to highlight new concepts and viewpoints that have relevance for the career counseling of those recovering from mental illness.

- All papers presented at this seminar identified stigma as a major roadblock to finding work and sustained employment. Therefore, engaging in advocacy, sensitizing schools, communities, and employers to mental health issues emerged as a vital issue. If career counseling is to be effective, it is important that the career counselor also shows allegiance to the cause of effective employment for the mentally ill. If it is publicly seen that the career counselor is "standing beside" the mentally ill person, committed to his or her wellbeing at work, public perceptions could be impacted.
- Self-help groups composed of the mentally ill were found to be effective in sustaining their employment. This could be a lead taken by the career counselor, and clients and their families could be facilitated in networking to support and help each other.

- Emphasis on individual training processes was found to be more effective than en mass training. This finding seems to indicate that one-on-one career counseling designed to formulate individualized career development plans would be more effective. A wider canvas of career options should be brought into the scope of career counseling for the mentally ill, rather than the options that have an overtly rehabilitation or vocational type of focus.
- Of particular relevance to the career counselor is a job-matching data base. This would comprise a list of available persons with an indication of their aptitudes and interests on the one hand and a list of job openings on the other hand. Such a system is being increasingly recognized as important for the reintegration of the mentally ill into the workplace.

As of now, the career development of individuals affected by mental illness is a theme that is poorly represented in the career guidance literature. While a significant amount of work has been done in relation to the vocational rehabilitation of the mentally ill, these efforts have not been adequately informed by the theories and principles of career guidance and counseling. On the other hand is the fact that the discipline of career guidance and counseling does not seem to have exercised adequate effort to theorize, build models, and develop applications with specific reference to the mentally ill. With the emerging recognition of the importance of career guidance, it is critical that the discipline actively engages with this highly neglected client group.

Conclusion

Strong evidence from the literature has been presented in this writing to demonstrate that reintegration into the world of work and reengagement with meaningful employment contributes significantly to recovery of those affected by mental illness and to maintenance of these improvements in health. As is well known to the career counselor, career success is

closely intertwined with the meaningfulness of the career to its practitioner. Frustration and dissatisfaction quickly become attending sentiments when a career is far removed from the individual's interests and inclinations. This is perhaps all the more true when working with the mentally affected. Models of vocational rehabilitation have made significant contributions to the reintegration of the mentally ill into the world of work. Yet, the young man's statement about candle making which titles this writing, throws light on what can go wrong when career counseling is not integrated into vocational rehabilitation services. When confronted by the multiple and sometimes profound disabilities experienced by a mentally ill person, the career counselor may be overwhelmed and may feel that his or her skill-set is not adequate or even relevant. Nevertheless, the career counselor could become pivotal, making significant contributions to improving the mentally affected person's quality of work life. Not only is the career counselor well positioned to identify the "right candle" for the recovering mentally ill person, he or she can contribute to the reinstatement of the person as a contributing member of society, rekindle the flame, and ensure that it burns bright and steady.

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Table 1
The Impact of the Symptoms of Mental Disorders on Work Performance

Main classification	Example of specific disorders	Key symptoms	Negative effects on work performance
<p><i>Schizophrenia:</i></p> <p>Perhaps the most severe psychotic illness; results in a devastating disorganization of personality.</p>	<p>Classified as: Simple, Paranoid, Hebephrenic, Catatonic, and Undifferentiated Schizophrenia</p>	<p>Loss of ability to distinguish between what is real and not real; delusions; hallucinations; emotional dysregulation; poor personal care.</p>	<p>Slowness in activities; low motivation; fluctuating concentration; emotional blunting; withdrawal from socializing; holding odd beliefs; displaying odd behaviour.</p>
<p><i>Mood Disorders:</i></p> <p>Severe psychotic illnesses; related to the dysregulation of emotions.</p>	<p>Mania</p>	<p>Elation of mood; overactivity; overconfidence; poor sleep; poor judgment.</p>	<p>Recovery is mostly complete with no residual symptoms on remission; recurrent attacks can interfere with study/work/family life. This could cause loss of employment.</p>
	<p>Depression</p>	<p>Lasting sadness; slowness of activities; loss of interests; suicidal ideas; guilt; hopelessness.</p>	<p>Recovery is mostly complete with no residual symptoms on remission; recurrent attacks can interfere with study/work/family life; attention and motivation maybe affected; feelings of helplessness/hopelessness may affect work performance.</p>
	<p>Bipolar affective disorder</p>	<p>Episodes of depression and mania at different times.</p>	<p>Unpredictability of episodes can cause uncertainties at work and loss of work and social time during the episodes of illness.</p>

Table 1 (cont'd)

Main classification	Example of specific disorders	Key symptoms	Negative effects on work performance
<i>Neurotic Disorders:</i> Less severe; the person is in touch with reality	Phobias	Avoidance of specific situations; mental tension; anxiety; specific, unreasonable dread and fear.	Restriction of life activities; can increase to a point at which the person may not even be able to leave home.
	Anxiety Disorder	General feelings of intense apprehension; palpitations; worrying.	Poor concentration; lack of confidence; pre-occupation with failure; easily fatigued; irritability; restlessness.
	Obsessive-Compulsive Disorder	Recurrent absurd and intrusive thoughts; over preoccupation with unnecessary details; compulsion to repeat an action meaninglessly; anxiety. Complete remission of symptoms is unusual.	Uncertain and unable to make a decision easily; tendency to start and stop a task intermittently; tentativeness about performance; low assertiveness; hesitant and constantly in doubt.
	Adjustment Disorder	Inability to cope with a situational stressor or life event and manifested as: sadness, lack of enjoyment, crying spells, fighting and recklessness.	Functions are impaired in relation to the stress inducing situation; tendency to ignore important tasks; avoidance of friends, family, and colleagues.

Table 1 (cont'd)

Main classification	Example of specific disorders	Key symptoms	Negative effects on work performance
<p><i>Disorders of adult personality:</i></p> <p>Personality Disorders are not an illness. They refer to ingrained, long standing, and chronic patterns of behavior that are disabling and significantly different from how the average person in the culture perceives, thinks, and feels, particularly in relating to others.</p>	Paranoid	Tendency to distrust and be suspicious of others; excessive sensitivity; concern that other people have hidden motives; tend to become socially isolated.	Overwhelming expectation that one will be exploited by others, hence experience difficulties in working with others; tend to be detached and suspicious. Can also become hostile toward colleagues.
	Schizoid	Lifelong pattern of indifference to others; emotional coldness; limited capacity to express feelings; preference for solitary activities.	Low energy levels at study and work; unable to develop close deep relationships; tendency to avoid responsibilities.
	Dissocial	Unconcern for feelings of others; disregard for social norms; inability to maintain relationships; insensitivity to guilt; low response to corrective action.	Can be disruptive at work; tends to break rules; oppositional to authority; impaired interpersonal relationships; may vandalize property; may have repeated legal problems.
	Histrionic	Excessive emotionality and self-dramatization; tendency to seek attention; easy suggestibility; excessive need for approval; overconcern with physical attractiveness; can exhibit inappropriately seductive behavior.	Job performance is governed by need for appreciation; can be manipulative in order to achieve; excessive sensitivity to criticism could affect performance; pride could affect willingness to change; decisions could be made impulsively.

Table 1 (cont'd)

Main classification	Example of specific disorders	Key symptoms	Negative effects on work performance
<i>Disorders of adult personality (Cont'd):</i>	Anankastic	Excessive doubt; preoccupation with details; rigidity and stubbornness; over-preoccupation with details, rules, lists, order, or schedule; overly scrupulous; excessive preoccupation with efficiency; pedantic and rigorously observant of social conventions; experience of insistent and unwanted thoughts or compulsions.	Feelings of excessive doubt, caution, and perfectionism can affect completion of job tasks and work can become a burden; has difficulties to work in a team; has a need for others to submit exactly to a personally preferred way of doing things; irrational unwillingness to allow others to function independently; tendency to withdraw and work alone if unable to get others to comply.
	Anxious(Avoidant)	Extremely sensitive to criticism; strong feelings of inadequacy; tendency to keep away from social interaction.	Extreme sensitivity to negative evaluation can affect work performance; social anxiety can cause avoidable errors at work; anxiety may inhibit aspiration and initiative.
	Dependent	Excessive dependence on others to meet emotional and physical needs; allowing others to make important decisions; unwillingness to make demands; helplessness when alone; limited capacity to take day-to-day decisions.	Low assertiveness can affect job performance; low capacity to work alone; low confidence to make decisions can affect career progress.

Note: This is not an exhaustive list. Interested readers are referred to the ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and guidelines (WHO, 1992).

Box 1

Psychosocial Dynamics of Reintegration into Work Roles: Case Note Excerpts

“I feel much better now. But how can I ever face my colleagues again? Memories of what I did keep coming back. And people tell me of what I don’t remember. It seems I threw things around and ran out of the office. I also remember the voices telling me that I should escape.” *32 year old male, Assistant Librarian in a college. Diagnosis: Paranoid Schizophrenia.*

“I went back to my office. But I don’t think it is going to work out. As soon as I entered the room went quiet. Then everyone came up and started speaking to me. It felt like a false friendless. Very unnatural. Like they had been coached to treat me correctly or something. Then all through the day, I would catch people staring at me and look away when I looked up at them. Can’t work like that.” *39 year old female, Accountant in a company. Diagnosis: Bipolar Disorder.*

“They are telling me that I stripped my clothes off and ran down the street. I only remember that vaguely. But if everyone else remembers, then how can I face them? When I heard that all my old fears started coming back.” *42 year old male, Associate in a Law firm. Diagnosis: Mood Disorder (Mania).*

“His outburst was major. Shouting and tore up files. He would not listen to anything I said. He was convinced that I was plotting to get him sacked. It is great he is back now. But still I feel he not his old self. As his friend I am never sure what will happen.” *33 year old male, close work mate of a 32 year old male. Diagnosis: Paranoid Schizophrenia.*

“I cannot let him handle the machines anymore. When he went mad 6 months ago, he nearly killed his co-worker with the tool he was holding. I cannot take that chance again. Nor will the workers accept. Best I can do is give a watchman job to him. *Owner of a furniture manufacturing factory, in response to the counselor’s attempt at reintegrating a highly skilled Product Engineer back into his workplace. Diagnosis: Mood Disorder (Mania).*

Note. Extracted from Unpublished Clinical Records (2000 to 2006) by G. Arulmani, 2006, The Promise Foundation, Bangalore, India.

Table 2
Short List of the Nine ICF Activity and Performance Domains, Scored for a Person with Anxiety Disorder

Short List of Activity and Performance Domains	PQ	CQ
Learning and Applying Knowledge		
Watching	0	0
Listening	0	0
Reading	1	0
Writing	1	0
Calculating (arithmetic)	1	0
Solving problems	1	0
General Tasks and Demands		
Undertaking a single task	0	0
Undertaking multiple tasks	2	1
Communication		
Receiving messages (spoken)	0	0
Receiving messages (non-verbal)	0	0
Speaking	1	4
Producing non-verbal messages	0	0
Holding a conversation	3	1
Mobility		
Lifting and carrying objects	0	0
Fine hand use (e.g., picking up, grasping)	1	1
Walking	0	0
Moving around using equipment (e.g., wheelchair)	0	0
Using transportation (e.g., car, bus, train, plane)	3	3
Driving (e.g., using bicycle, motorbike, car)	4	3
Self Care		
Washing oneself	0	0
Caring for body parts (e.g., grooming)	0	0
Toileting	0	0
Dressing	0	0
Eating	0	0
Drinking	0	0
Looking after one`s health	0	0
Domestic Life		
Accessing goods and services (e.g., shopping)	2	1
Preparation of meals (e.g., cooking)	3	2
Doing housework (e.g., washing dishes)	3	2
Assisting others	3	2
Interpersonal Interactions		
Basic interpersonal interactions	1	1
Complex interpersonal interactions	3	2
Relating with strangers	4	2
Formal relationships	3	2
Informal social relationships	2	1
Family relationships	2	1
Intimate relationships	3	2

Table 2 (cont'd)

Short List of Activity and Performance Domains	PQ	CQ
Major Life Areas		
Informal education	0	0
School education	0	0
Higher education	0	0
Remunerative employment	4	2
Basic economic transactions	0	0
Economic self-sufficiency	4	2
Community, Social and Civic Life		
Community Life	3	1
Recreation and Leisure	3	1
Religion and Spirituality	0	0
Human Rights	0	0
Political Life and Citizenship	0	0

Note. PQ= Performance Qualifier (performance restriction); CQ: Capacity Qualifier (activity limitation).

Scoring key:

0 = No difficulty; has no problem.

1 = Mild difficulty; problem present less than 25% of the time; person can tolerate; happened rarely over the last 30 days.

2 = Moderate difficulty; problem present less than 50% of the time; interfering with day to day life; happens occasionally over the last 30 days.

3 = Severe difficulty; problem present more than 50% of the time; partially disrupting day to day life; happens frequently over the last 30 days.

4 = Complete difficulty; problem present more than 95% of the time; totally disrupting day to day life; happens every day over the last 30 days.