THE CLUBHOUSE EXPERIENCE

A Thesis in
Counselor Education

by

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Submitted in Partial Fulfillment
of the Requirements
for the Degree of

Doctor of Philosophy

December 2007
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Abstract

Mental health clubhouses are community centers that serve the psychosocial and vocational needs of individuals with serious mental illness. The services utilize strength-based interventions that emphasize member-to-member support and require maximum member inclusion in all of the duties needed to run the centers. Through mutual support and the performance of in-house duties, members improve social and vocational skills while gaining a sense of empowerment and inclusion in the community. These clubhouses are being opened with an increasingly regularity, yet very little research has looked at this model of service.

In an effort to better understand the clubhouse experience, this qualitative investigation compiled and analyzed 14 interviews with clubhouse members. The results revealed that clubhouse members are overwhelmingly satisfied with the services. A composite portrait of the clubhouse paints it as a safe and welcoming environment where people with serious mental illness can learn about themselves and others, while bettering the skills needed for improved living and employment. Included in this report is a review of the literature regarding clubhouse and its relevant issues and a discussion of the implications of the findings and the limitations of this research.
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ACKNOWLEDGMENTS

I would like to offer a sincere thank you to my friends, family, and all of the Penn State faculty and staff that have supported and encouraged me throughout my graduate studies. This includes: Pam Anderson, Chris Andrus, Liza Conyers, James Herbert, Darla Homan, Heather Homan, Judy Kauffman, Connie Matthews, Spencer Niles, Christine Rodgers, and Keith Wilson.

Special appreciation goes to JoLynn Carney, Peggy Lorah, and Dan Marshall (members of my dissertation committee) for taking interest in this effort and in providing thoughtful and challenging feedback.

My deepest gratitude goes to Brandon Hunt, my committee’s chairperson, advisor, and mentor. Thank you for sharing your wisdom and humor. I will always value your unwavering encouragement and support.
Chapter 1

INTRODUCTION

The aim of this research effort is to better understand the mental health clubhouse experience. Clubhouses are community programs that strive to help individuals with serious mental illness to live lives that are as full and satisfying as possible. Specifically, this research will attempt to illuminate the essence of the clubhouse experience through the words of its members. This is important because during the last decade, community mental health programs have more readily embraced clubhouses as a helpful and cost effective adjunct to traditional rehabilitation interventions (International Center for Clubhouse Development [ICCD], 2002c).

Surprisingly, no research has been conducted to understand what specifically, if anything, is unique about the clubhouse experience. To capture the essence of the clubhouse experience, I conducted a series of hour-long interviews with 14 current clubhouse members using phenomenological qualitative inquiry to guide the process. Included in this effort is a review of the professional literature that addresses mental health clubhouses and concepts relevant to its goals.

Mental Illness

Typically, serious mental illness refers to schizophrenia and other psychotic disorders, mood disorders, and anxiety disorders (Scheid, 1995). These conditions are most often defined by the criteria outlined within the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [APA], 2000) and are often marked by disruptive symptoms such as delusions, hallucinations, disorganized speech, depressed mood, and diminished interest in activities. According to Garske (1999),
psychiatric rehabilitation often limits its services to the most disabling conditions, requiring clients to either have "chronic mental illness" or "serious and persistent mental illness" (p. 22). Regardless of diagnostic categories or specific symptoms, severe mental illnesses typically limit a person's ability to live and function independently, and to successfully acquire and sustain employment (Garske, 1999).

Many of the symptoms defining serious mental illness are antithetical to the characteristics often needed for success. According to Lysaker (1995), the most problematic of the manifestations of schizophrenia is the prevailing feature of avolition. Avolition, associated with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) criteria of negative symptoms, is marked by inertia, ambivalence, anhedonia (an inability to experience pleasure), alogia (an inability to speak), and/or negativism (APA, 2000). Lysaker argues that avolitional symptom complex, not psychosis, is the primary disabling factor for people with serious mental illness. The author argues that cognitive disturbances and positive symptoms (e.g., hallucinations and disorganized speech) are more readily apparent, but it is the more insidious and enduring negative symptoms that interfere with “normal” functioning. Similarly, Bebout (1995) suggests that the symptoms experienced by people with serious mental illness, such as schizophrenia, interfere with the skills needed to properly understand oneself and the environment. It is this loss of a cohesive sense of identity, according to Bebout, that leaves people with serious mental illness with no basis to formulate goals or even identify preferences of treatment.

Oftentimes, serious mental illness can be characterized by deviations from the generally accepted standards of behaviors and experiences. Costin and Draguns (1989)
group these characteristic along four dimensions: (a) departures from established social standards, (b) poor contact with reality, (c) intellectual and social inefficiency, and (d) personal distress. Deviations from acceptable social norms can include extreme behaviors (e.g., unexplainably shouting) that may even be illegal (e.g., harassing phone calls). Poor contact with reality may include distorted perceptions (e.g., hallucinations, delusions, or paranoia), disorientation (e.g., inability to recall the current year), or inappropriate physical activity (e.g., standing rigidly for hours). Intellectual and social inefficiency may include a person’s inability to complete age-appropriate tasks (e.g., attending to personal hygiene). Personal distress can include anxiety, physical discomfort, phobias, depressed moods, or demoralization. Importantly, Costin and Draguns (1989) stress the existence of a singular symptom may not be indicative of a serious mental illness. Instead, they explain that cultural contexts must be considered and that having several of the aforementioned symptoms may indicate the presence of a mental illness.

The exact number of people affected by mental illness is difficult to determine, but Kessler, Chiu, Demler, and Walters (2005) estimate that, within a given year, 26% of all adult Americans will experience some form of a diagnosable mental illness. Onset for most mental illnesses occurs within young adulthood. Of these, an estimate of nearly 10% of the American adult population will experience a mood disorder (Kessler et al., 2005), 18% will experience an anxiety disorder (Kessler et al., 2005), and just over 1% will experience schizophrenia (Regier et al., 1993). About 6% of the U.S. population experiences severe symptomologies that greatly reduce day-to-day functioning (Kessler et al., 2005). The effects are far-reaching and the World Health Organization (2002) reports that mental illness is the leading cause of disability for young adults.
The current formalization of a classification system of mental illness and modern terminology began taking shape about 100 years ago (Torrey, 1983). Inarguably, mental illness has been a part of humankind since pre-historic times. Skull fragments from pre-historic people show evidence of trepanning, a practice of cutting away portions of the skull in what is thought to be an effort to release psychic pain, and 4,000 year old Mesopotamian tablets depict mental health healers (National Association for Mental Health, 2007). Later, Hippocrates (ca. 460 B.C.) detailed clear portraits of psychosis and references to madness can be found in many ancient sacred texts (e.g., the Old Testament, Talmud). Understandably, the views of the etiology of mental illness and the treatment of people with mental illness have varied greatly throughout the centuries (Torrey, 1983). Most notable was Hippocrates’ radical dismissal of divine or magical causations of mental illness. Instead, he promoted the idea that mental illnesses had organic etiologies and, as such, encouraged humane treatments to care for the minds and bodies of individuals with mental illness (Costin & Draguns, 1989). Hippocrates’ hypotheses, however, were discarded during the Middle Ages when it was again widely believed that evil spirits and demonic possession caused mental illnesses. Such beliefs inspired the brutalization and torture of many people with mental illness (Brodwin, Tellez, & Brodwin, 1995).

During the mid-1500s, European societies began seeing mental illness as a sickness and efforts were made to provide care. This care was primarily in the form of housing and medical treatment. Mental health treatments, however, were severely lacking and individuals with serious mental illness were often confined to asylums. These asylums became notorious for their abominable conditions and inhumane treatments.
Several centuries of confinement and torture of people with mental illness gave way to increased governmental interventions and the establishment of a more humane system of Almshouses. These changes in the treatment of people with mental illness reflected the general changes in attitudes, values, and economic environment of the times (Woodside & McClam, 2006).

As industrialization and urbanization increased, larger hospitals were built to meet the demands of the increased concentrations of the population. The conditions within these larger hospitals, however, continued to be poor. As the so-called Moral Movement of the 19th took hold in the U.S. and England, vast improvements in treatment were developed. During this period, it was seen as virtuous to care for people with illnesses, and this led to a reformation of the prison-like institutions. Additionally, new ideas about mental illness and its origins began to emerge at the end of the 19th century (Woodside & McClam, 2006).

Psychiatry and greater understanding of the brain began to flourish during Victorian times (Costin & Draguns, 1989). Scientists such as Emil Kraepelin, Adolph Meyer, and Eugene Bleuler worked to develop and refine a system of diagnosing and treating mental illness. Their work inspired and laid the groundwork for Sigmund Freud, who radically changed the way mental illness was viewed and treated. Freud asserted that mental illness was the result of unconscious motives and unresolved intrapsychic conflicts. His practice of psychoanalysis contended that, through talking with a trained expert, an individual could reveal important clues regarding the seeds of his or her personal distress. Many of Freud’s claims were (and remain) controversial and the efficacy of his treatments for people with serious mental illness are questionable. His
influence upon psychology and the treatment of people with mental illness, nevertheless, 
still reverberates (Costin & Draguns, 1989).

The popularity of psychoanalysis continued to grow during the early 20th century, 
yet the treatment of serious mental illness remained fairly static until the 1950s. People 
with serious mental illness were still predominately treated in large, in-patient facilities. 
The introduction of Thorazine, a powerful antipsychotic drug, in 1954 began a gradual 
shift away from the institutionalization of people with serious mental illness. By 
effectively reducing the symptoms of psychosis, Thorazine allowed individuals to be 
discharged from long-term hospital care into community-based care. As 
psychopharmacological advances continued, so did the de-institutionalization movement 
– culminating in the shuttering of many mental health hospitals during the 1970s and 1980s (Costin & Draguns, 1989).

This dramatic shift from hospital-based to community-based care created strains 
on the unprepared communities receiving recently discharged individuals (Woodside & 
McClam, 2006). Local communities struggled to develop systems of care to meet the 
needs of individuals with complex psychological, social, medical, and vocational needs. 
The current systems of community-based mental health treatment attempt to provide 
many aspects of hospital care (e.g., easy access to medical and psychiatric care, 
psychosocial supports), but under the guiding principle of doing so within the least 
restrictive environment (Brodwin et al., 1995).

The cornerstone of this care, however, remains reliant on medications (Brodwin et 
al., 1995). The number of useful medications available for the treatment of mental illness 
has greatly expanded over the years and many of these medications have been proven to
be highly effective in reducing the symptoms of mental illness. Importantly, medications alone are not the most effective treatment strategy. It has been widely established that medication, in conjunction with other therapeutic interventions (e.g., psychosocial education, counseling, skills training), is more helpful than a singular intervention of medication (Costin & Draguns, 1989).

Despite the advancements in treatment, the overall effects of serious mental illnesses and society’s on-going stigmatization of people with mental illness often force people into a marginalized, second-class status. Clubhouses, however, attempt to actively remedy such inequities by promoting an atmosphere of acceptance, empowerment, and recovery for people with serious mental illness. Toward this end, the ICCD’s (2002b) mission statement asserts that inclusion within a vital and caring community greatly aides in the rehabilitation process. The ICCD mission statement explains that a “clubhouse community offers respect, hope, mutuality, and unlimited opportunity to access the same worlds of friendship, housing, education and employment as the rest of society” (para. 1). These principles are reflected in a recent mental health movement known as mental health recovery. The recovery model has been adopted as an integral component within clubhouses.

Defining Recovery

The professional literature addressing mental health recovery has increased dramatically over the last decade, but there exists a lack of consensus as to exactly what recovery is (Bullock, Ensing, Alloy, & Weddle, 2000; Davidson, Lawless, & Leary, 2005; Drake, 2000; Jacobson, 2004). Many of the definitions, however, share a great deal of commonalities (Lysaker & Buck, 2006). Foremost in these writings is the basic tenet
that mental health recovery is a process of healing (White, Boyle, & Loveland, 2004). In an effort to concisely describe recovery, Lysaker and Buck (2006) suggest that it can be viewed as “adaptive changes in people’s appraisals of themselves and their future potential that promotes a holistic movement toward health” (p. 29). Within this, is the assertion that people with serious mental illness can move beyond the commonly accepted prognosis of a progressively deteriorative condition (Anthony, 2000).

The premise that a mental health diagnosis was a sentence of a downward spiral of functioning was not a subtle, misguided attitude, but a well-established “truth” within psychiatry (Harding, Zubin, & Strauss, 1987). As an example, the foremost-utilized tool within psychiatry, the *Diagnostic and Statistical Manual of Mental Disorders – III* (APA, 1980), explicitly specified that deterioration in day-to-day functioning was a required symptom for a person to receive a diagnosis of schizophrenia. The mid-1980s, however, was marked by an increasingly vocal opposition to the notion that an imperative decline was inescapable for people with mental illness (White et al., 2005).

Personal histories provided by authors such as Deegan (1988) and Unzicker (1989) gave testament to the fact that people can experience a serious mental illness and reemerge stronger from the struggles. Furthermore, groundbreaking longitudinal studies of people with serious mental illness dispelled any notions that the aforementioned claims of recovery were merely anecdotal oddities (Harding, 1989; Harding, Brooks, Ashikagan, Strauss, & Breirer, 1987; Harding, Zubin, & Strauss, 1992). Most notably, Harding et al.’s series of studies asserted that nearly 75% of the participants with serious mental illness experienced some level of recovery. Subsequently, the APA acknowledged the mounting contradictions regarding the course of mental illness, and the revised edition of
the Diagnostic and Statistical Manual of Mental Disorders-III-R (APA, 1987) removed the diagnostic criterion that it was a life-long illness (White, Boyle, & Loveland, 2005).

Prescient authors such as Anthony (1993) urged that a reformation of the mental health service delivery system needed to include the “guiding vision” (p. 11) of recovery. The term recovery, however, created some confusion (Jacobson, 2004). The term has a long-standing association with Alcoholics Anonymous (AA), as it is even included in the title of one of the organization’s guiding books, Alcoholics Anonymous: The Story of How More Than One Hundred Men Have Recovered from Alcoholism (Alcoholic Foundation, 1939). Widely accepted within drug and alcohol rehabilitation, recovery for people with substance abuse disorders is viewed as abstaining from drug and alcohol use, mutual group member support, and adhering to healing changes in one’s life. Additionally, recovery has also been a commonly used term in describing a return to full functioning for individuals who experience a variety of physical disabilities. Positive changes and improved functioning can be integral to mental health recovery, but unlike addictions and physical rehabilitation’s visions of recovery, mental health recovery has no distinct substance from which to abstain and no universal ideals of a “normal” level of functioning.

Still, others were uncertain as to whether recovery was an outcome or a process (Jacobson, 2004). Process-focused questions arose, asking how does one enact and maintain the process? Alternately, if mental health recovery is an outcome, how does one measure that outcome? Some authors, such as Jacobson (2004), contend that early on, the movement was awash with sloganeering and rhetoric (e.g., “Next Step: Recovery” [p.
with no meaningful guidelines to help clients and practitioners fully understand and research the concept.

Traditional mental health outcome measures (e.g., symptom reduction) simply do not fit within the recovery model (Corrigan & Ralph, 2005). Unlike the typical summative mental health measures, the recovery model relies on more fluid, personalized formative measures. As such, one could be viewed as achieving a basic life goal (e.g., obtaining employment or independent living) *despite* on-going symptoms. Recovery outcomes need not focus solely upon achieving a “normal” state, but instead can focus on achieving an *improved* state. Many, however, view outcome measures as inappropriate within the recovery movement. For those people, recovery is a life-long, on-going process of *adjusting* to one’s environment and illness (Corrigan & Ralph, 2005).

The confusion surrounding exactly what mental health recovery is may stem from its relatively nascent status. Some authors, such as Anthony (2000), suggest that the confusion exists because mental health recovery is such an individualized experience, rendering it impossible to precisely define. Recovery, according to Anthony, is “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles” (p. 159). Additionally, he explains that recovery for individuals with serious mental illness is the dynamic process of living life fully, in a satisfying, purposeful, and fully engaged manner.

As an early advocate for the inclusion of recovery within the mental health service system, Anthony (1993) attempted to summarize some guiding principles that undergird the recovery movement. Most striking in his efforts to define recovery was the jettison of the so-called “medical model” of treatment. The medical model of treatment is
built upon the identification of an illness, a reliance on an “expert’s” treatment of that illness, and the elimination of the illness. Total symptom abatement (i.e., a cure) defines success within the medical model. Such an orientation fosters dependence on professionals, leaves little room for individual differences, and provides no instillation of hope for people experiencing mental illness (Anthony, 1993).

Alternatively, the goal of recovery is not an elimination of the illness and a return to pre-illness levels of functioning (Davidson, O’Connell, Tondora, Lawless, & Evans, 2005). Instead, recovery views mental illness simply as one aspect of a whole person. Importantly, recovery does not focus solely on the effects of the illness on an individual, but takes into consideration how environmental impediments (e.g., stigma, poverty, homelessness, and poor social supports) affect an individual’s ability to fulfill one’s life goals (Corrigan & Ralph, 2005; Davidson et al., 2005).

In an effort to remedy the confusion surrounding recovery, Anthony (1993) outlined a set of seven factors that define mental health recovery. The factors explain that recovery: (a) can occur without professional assistance, (b) can include naturalistic support systems, (c) can happen regardless of one’s ideas regarding causation, (d) can occur during symptom relapse, (e) is a unique, personal process, (f) includes choices for treatment, and (g) acknowledges that the environmental consequences of the illness are sometimes more trying than the illness itself. Many other authors have also attempted to define recovery. Mead and Copeland (2000) identified five facets of the recovery process: (a) hope, (b) individual responsibility, (c) on-going education, (d) self-advocacy, and (e) peer support.
Moreover, Anthony (1993) acknowledged that many of the mental health recovery movement’s ideas are built upon the foundation initially established within the psychiatric rehabilitation movement. The psychiatric rehabilitation model was developed to meet the needs of individuals who, during the wave of deinstitutionalization, were summarily discharged from long-term care facilities (i.e., state hospitals) into unprepared communities (Cohen, Nemec, Farkas, & Forbes, 1988). In an effort to clarify the complex continuum of care needed for recently discharged individuals, Cohen et al. identified the integral service components of psychiatric rehabilitation. Those services are: (a) mental health treatment, (b) crisis intervention, (c) case management, (d) rehabilitation, (e) enrichment, (f) rights protection, (g) basic support, (h) self-help, and (i) wellness/prevention. This all-encompassing set of services (often referred to as Community Support Services) was identified as being vital to assisting people with serious mental illness. Many communities have adopted this strategy, but, according to Anthony (2000), it falls just short of including key components of recovery.

The Clubhouses Model

The term clubhouse may evoke images of an informal network of youths gathering for social and recreational pursuits. And, in part, mental health clubhouses are community centers where people can gather, build friendships, and plan events. Despite the informal sounding moniker, clubhouses serve a broader purpose and are expected to adhere to rigorous standards of service. These standards are set by the ICCD, which acts as the formal accreditation agency for clubhouses. The ICCD works to ensure that all participating clubhouse communities provide an appropriate physical environment, as well as a vast array of quality services. For certification, a participating clubhouse must
meet and maintain 36 standards (see Appendix A), addressing the areas of (a) membership, (b) relationships, (c) space, (d) the work-ordered day, (e) employment, (f) education, (g) functions of the house, and (h) funding, governance, and administration (ICCD, 2002a). The overarching goal of these standards, according to the ICCD (2002c), is to ensure that participating clubhouses provide supportive communities for people with serious mental illnesses.

These communities, modeled after New York City’s Fountain House, are centers offering education, housing, employment, advocacy, social support, outreach, and skills training. Importantly, clubhouses do not focus on individuals’ illnesses (ICCD, 2002c). Mental health services have traditionally followed the medical model of patient/healer relationship. That is, a “sick” individual seeks out a specialist who, through a focused exploration of the illness, attempts to eliminate the disease. Alternately, clubhouses promote an atmosphere of mutual support where each individual is seen as the expert over his or her life. This shift from the expert healer to individualized, personalized treatment planning encourages people to take more active roles in guiding their lives (ICCD, 2002c).

Incorporating concepts from the recovery model, clubhouses do not focus on illness and the eradication of symptoms (ICCD, 2002c). Instead, clubhouses encourage strengths-focused planning. Individuals are not seen as sick patients needing an expert’s healing, but rather as members trying to move forward in their lives in personalized, meaningful ways. Furthermore, the clubhouse staff is not viewed as the experts over members’ lives, but as generalists who offer encouragement, support, and education (ICCD, 2002c).
These centers are open to any individuals with mental illness and members are not expected to pay any out-of-pocket dues or fees for their memberships. Participation in a clubhouse gives members the opportunity to work alongside a small number of generalists in fulfilling the duties needed to operate a community center (e.g., clerical, maintenance, cooking). By doing so, individuals with serious mental illness are able to try out new roles, build self-confidence, and establish work histories (ICCD, 2006b).

The clubhouse system of in-house voluntary services and skill building programs arose during the late 1960s. As the deinstitutionalization movement took hold, many of the individuals discharged into the community had no skills or work histories, leaving them with no means to secure employment (Szymanski & Parker, 1996). As Fountain House members tired of the dilemmas caused by calls for “experience needed” for entry-level employment, they developed an onsite program that allowed members the opportunities to develop skills and experiences that lent themselves toward employment within the broader community (Marrone & Gold, 1994). Additionally, members began to establish relationships with community businesses that were willing to hire clubhouse members. This model, referred to as transitional employment, remains a cornerstone of the clubhouse experience.

My Initial Exposure to the Clubhouse

Upon first hearing about the clubhouse model, I was intrigued by the idea of peer-support for individuals with serious mental illness. Upon visiting a local clubhouse, I became thoroughly impressed with its cooperative spirit and sense of community. Early on, I knew that I wanted to pursue research into the clubhouse model. My interests in this topic were further fueled by my participation in a similar research project that examined
the overall treatment experiences of individuals with mental illness (Hunt & Roth, 2007). In that research, several of the participants expressed a great deal of satisfaction with the services offered at clubhouse. The clubhouse component, however, was only a minor piece of that research and I thought that it was important to do a more specific investigation into the clubhouse experience.

Having an interest in one’s research pursuits is not uncommon, but within phenomenological qualitative research, it is recommended that such biases be formally addressed. This process of self-reflection and examination of potential biases is known as *epoche* (Moustakas, 1994). This epoche, according to Moustakas, is an effort to acknowledge and set-aside as best possible all preconceived ideas about the phenomenon being studied. Moustakas (1994) acknowledges that to truly clear one’s mind of all knowledge of the subject is not a reality, but asserts that researchers must make every effort to bracket earlier notions. This, he suggests, helps one to see the data as it truly is.

Importantly, the greatest influence upon my notions of clubhouses stem from my first visit to one. What I witnessed was a skeletal staff of two full-time employees amongst the activities of 30 or so members. The members themselves were conducting the majority of the on-going action. My site tour guide, a member herself, walked me through the open-layout building, directing my attention to different locations and explaining how each area was typically used. Within the kitchen, members were cleaning-up after their lunch services. At one set of desks, a member was using a telephone, encouraging the person on the other end to drop-by “since we haven’t seen you in awhile.” At a computer, one member was instructing another on how to use a software program to make invitations for a clubhouse function. Throughout the tour, my
guide continued to espouse the virtues of the clubhouse. She explained that she has been utilizing community mental health services for several years and that the clubhouse was, perhaps, the most valuable to her.

Since, on the surface, the clubhouse model seems to positively affect individuals with mental illness, it is remarkable that investigators have not made more efforts to understand what occurs within them. Having invested a good deal of time and effort working in a variety of mental health programs, I am driven to understand how to best help people with mental illness. At times, I still find myself perplexed by what is truly helpful. Moreover, in this age of cost effectiveness and empirically based “best practices,” I wanted to provide some details that may help people in determining where clubhouses fit in.

Furthermore, the emphasis on self-advocacy and mutual support raises questions regarding exactly what a helper’s role should be in a clubhouse setting. Undoubtedly, my educational and training experiences have provided me with a useful framework for understanding the helping relationship, but hearing my tour guide’s account of peer-to-peer support further fueled my questions of how to best serve people with mental illness. My interest in this topic is, by no measure, a search for the positivist pursuit of an absolute truth or an epistemological investigation of how helpers can know what is helpful, but is a more practical understanding of what the members find useful in their day-to-day clubhouse experiences.

From my training, I have a clear understanding of counseling theories and research, and have become comfortable employing the requisite skills for providing services, but these ideas and models have been predominately created from the
perspectives of theoreticians, practitioners, and researchers. The clubhouse model, however, calls into question just how much of a role counselors and rehabilitation specialists need play in people’s recovery. Importantly, I think that such ongoing, formative questioning of service delivery paradigms is a valuable and ethically essential pursuit.

Goal of This Research Project

Since there is a scarcity of research efforts specific to the process that occurs within clubhouses, it seems that any effort to advance the understanding of this would be invaluable. A few published research efforts exist, but nearly all of them are outcome-focused quantitative investigations. Such studies include analysis of how to best implement and effectively manage a clubhouse (Lucca, 2000), its effects on vocational rehabilitation (McKay, Johnsen, & Stein, 2005; Marcias, 2001; Schonebaum, Boyd, & Dudek, 2006), and cost analyses of clubhouses (Cowell et al., 2003; McKay, Yates, & Johnsen, 2005). These efforts contribute little to the understanding of what clubhouse members appreciate about the clubhouse and how member-to-member support affects individuals. Undeniably, the aforementioned investigations were indeed worthy pursuits, yet they inexorably exclude the emic perspective.

Moreover, a review of the professional psychiatric rehabilitation literature reveals an overall lack of varied perspectives regarding the experiences of people with serious mental illness. The literature predominately examines outcome measures of mental health rehabilitation efforts, or elucidates the views of the researchers and/or providers of mental health services. The clubhouse model, however, stresses that the recipients of services need to have a more resonant voice in both directing services and research
With this in mind, there is inarguably a shortage of investigations of the firsthand reports by clubhouses members.

Similar to other health services, the mental health service delivery system has been under scrutiny to find the most effective and fiscally responsible means in meeting client needs. Since clubhouse members volunteer to attend to many of the operational duties, the cost of running a clubhouse is significantly less than other rehabilitation interventions (Cowell et al., 2003; McKay et al., 2005). As such, communities around the globe are looking to utilize clubhouses as an inexpensive means to accommodate individuals with serious mental illnesses.

Community mental health services have historically been driven by the “expert” guidance of case managers, counselors, vocational specialists, and so forth. The clubhouse model, however, imposes a radical shift that de-emphasizes the professional’s role in treatment. This paradigm shift has not been studied despite the existence of over 400 clubhouses in 32 countries, serving more than 50,000 people (Fountain House, 2006).

An increased understanding of what occurs within the clubhouse and between members may offer information as to how aggressively this model should be promoted while providing insight into interventions that clinicians may be underutilizing. This research effort attempted to address this deficit through the gathering of first-hand accounts of how clubhouse members view the clubhouse. Through the use a phenomenological inquiry, I have attempted to capture, as best possible, the essence of the clubhouse experience. In doing this, I interviewed 14 active clubhouse members selected from both a rural clubhouse and an urban clubhouse. These interviews were
semi-structured with the focus on what, if anything, makes the clubhouse model valuable to its members. Importantly, this qualitative project may provide a foundation for future researchers to choose or develop psychometric tools for investigations regarding clubhouses and/or related community mental health services.
Chapter 2

REVIEW OF LITERATURE

Clubhouses are seen as an alternative to traditional community mental health programs for people with serious mental illness (ICCD, 2002c). People with serious mental illness are often limited to day-treatment programs (day-long, outpatient mental health services with an emphasis on psycho-educational group work). Typically, day-treatment programs focus on providing information about issues such as symptom management, behavior modification, and medication issues. Alternately, clubhouses are community centers where people with serious mental illness can join with others to focus on their individualized life goals. The emphasis at clubhouses is not on illness, but on individual strengths. The guiding vision of these clubhouses emphasizes recovery and mutual peer support, leading toward living a full, productive life (ICCD, 2002c).

It is generally acknowledged that the first clubhouse took shape in New York City in 1948, when a loose-knit collective of individuals with mental illness formalized an agreement to provide support for each other (Fountain House, 2006). This organization came to be known as the Fountain House center, and has since become the template for all clubhouses. As such, all participating clubhouses are expected to provide members with strength-focused services that encourage empowerment and recovery from the debilitating effects of serious mental illness (ICCD, 2002c). Despite its inception over 58 years ago, the clubhouse model has not been widely researched.

Costs Analyses and Vocational Rehabilitation

As previously noted, there are several research efforts that examine how to implement and effectively maintain clubhouse programs and cost analysis of such
interventions (Cowell et al., 2003; Lucca, 2000; McKay, Yates, et al. 2005). Most of the research attention, however, is directed toward the vocational rehabilitation component of clubhouses. Within the body of clubhouse-focused literature, the most notable conclusions highlight the striking cost differences between the clubhouses’ efforts and other community programs of psychiatric rehabilitation (Cowell et al., 2003; McKay, Yates, et al. 2005). McKay, Yates, et al. calculated that U.S.-based clubhouses spend $3,684 annually per person, which is less than similar service provided by vocational rehabilitation programs ($3,757), community mental health services ($6,818), and Assertive Community Treatment programs ($11,688). These figures, however, simply reflect cost per person and do not measure effectiveness or cost-to-value ratios.

In an effort to determine efficacy of one of the cornerstone functions of clubhouses, McKay, Johnsen, et al. (2005) examined the vocational rehabilitation components of clubhouses. Their large-scale effort of distributing and collecting self-report surveys to clubhouse members yielded a sample of 1,702 members in Massachusetts. Specifically analyzed were the three different modes of employment rehabilitation found within the sample: transitional employment (representing 37% of the sample), supported employment (27%), and independent employment (36%). Traditionally, clubhouses have relied on the transitional employment model, which is built upon employers having a working agreement with the clubhouses. The clubhouses are contracted to provide appropriate job placement for its members into work positions. These placements are usually time-limited (6-9 months), as different clubhouse members “try-on” the position. The clubhouses typically provide training, on-site support, and
guaranteed coverage while members develop the skills to successfully fulfill the position (Drake, McHugo, Becker, Anthony, & Clark, 1996).

More recently, however, clubhouses have encouraged and incorporated other models of vocational rehabilitation. Specifically, they have begun to include supported employment and independent employment programs (McKay, Johnsen, et al. 2005). Supported employment offers members support and encouragement (on and off the jobsite), but differs from transitional employment in that it is not time-limited and it emphasizes that the employment contract is between the employer and employee. Alternately, the independent employment model is essentially competitive marketplace employment with no on-site support and no clubhouse/employer relationship. In investigating these three models, McKay, Johnsen, et al. used self-report data and compiled descriptive statistics regarding member demographics and employment success (e.g., days worked, hours worked, pay rate).

Overall, McKay, Johnsen, et al. (2005) found that the clubhouse model, regardless of the three vocational rehabilitation interventions, had an “impressive” (p. 30) positive impact upon employment for its members. They concluded that members who obtained independent employment tended to work more hours (21 hours per week vs. 14 hours per week for transitional employment and 18 hours per week for supported employment) and averaged a higher hourly pay rate than their counterparts ($7.59 vs. $6.34 for transitional employment and $6.91 for supported employment). Significantly, people holding independent employment worked an average of 361 days since joining a clubhouse, whereas people within transitional employment worked 146 days, and people within supported employment worked 300 days. Additionally, the types of employment were
fairly similar for all groups, with the bulk of positions being in maintenance or light industry. The transitional employment sample, however, had a slightly higher percentage of members within clerical jobs (18.5% vs. 11% for supported employment and 12% for independent employment). McKay, Johnsen, et al.’s study provides a wealth of details describing what employment looks like for members within a clubhouse. Unfortunately, this research relied solely on client self-reports (i.e., no concrete documentation from the employers or any direct observations) and did not include a non-clubhouse vocational rehabilitation program comparison group or any control group with which readers could compare.

Macias’ (2001) investigation of clubhouses, however, did include a comparison group. This extensive investigation evaluated outcomes for participants who were either employed under a Program for Assertive Community Treatment (PACT) program or through a clubhouse. The PACT model serves a similar client-base, but differs in philosophy. Established in the 1970s, the PACT model of vocational rehabilitation stresses the importance of professional treatment specialists quickly securing employment for clients (Russert & Frey, 1991). The emphasis is on obtaining and placing clients into “real-world” work situations and then, through job supports, helping clients develop the needed work skills. This approach foregoes the clubhouse model’s initial segregation of in-house employment, and immediately places clients into an integrated work environment. Once in the work environment, individuals are supported by a variety of treatment specialists (e.g., job coaches, vocational counselors, case managers) with the goal of helping clients gradually gain the skills needed for successful competitive employment (Russert & Frey, 1991).
In her efforts, Macias (2001) tracked 175 participants over a period of 24 months. She gathered a variety of data sources, including (a) clinical records, (b) participant interviews, (c) employment records, and (d) daily service logs. Macias found the PACT model to be superior in job retention (81% for PACT vs. 60% for clubhouse participants) and overall competitive employment rates (64% for PACT vs. 59% for clubhouse participants). Clubhouse participants, however, worked more days (\(M = 254\)) than PACT participants (\(M = 173\)), earned a higher hourly rate of pay ($7.31 for Clubhouse vs. $6.24 for PACT participants), and were more likely to be in white-collar professional positions. When considering job retention rates, employment rates, and hourly pay, the two models demonstrated fairly similar total earnings for the study’s two-year duration ($262,475 for clubhouse members vs. $211,310 for PACT participants). The cost per person analysis revealed that the PACT program, for the study’s two-year duration, cost considerably more per person ($8,494) than the clubhouse program ($4,146; Macias, 2001).

The information yielded from Macias’ study is compelling, in that both programs resulted in considerable successes for individuals who commonly hold one of the highest unemployment rates (Becker & Drake, 1994). Although Macias’ study sheds more light on the effectiveness of two vocational rehabilitation programs, it still lacks a “no treatment” control group for comparison. This lack of information begs the question as to whether people in vocational rehabilitation programs fair any better than those with no support services. Additionally, Macias’ cost analysis only considers “direct costs,” which does not take into consideration the value returned to the clubhouse support system through unpaid, member-supplied volunteer services (Cowell et al., 2003). Furthermore,
no such cost analysis can capture the therapeutic value gained and intrinsic rewards earned through clubhouse members’ mutual support and volunteerism.

Similar to Macias’ research, Schonebaum et al. (2006) found that both the clubhouse and PACT models had significant effects upon successful job placement. Their 30 month tracking of 170 randomly assigned individuals found that 74% of the PACT group found at least one job, compared with 60% of the individuals assigned to the clubhouse treatment. The individuals within the clubhouse treatment, however, worked significantly more weeks (21.8 vs. 13.1) while earning a significantly higher average hourly pay rate ($7.38 vs. $6.30) than those in the PACT treatment (Schonebaum et al., 2006).

One study that looked primarily into the effects of the clubhouse upon its members’ work performances found encouraging results (Yau, Chan, Chan, & Chui, 2005). Yau et al.’s study examined the performances of 17 clubhouse members on simulated workplace tasks upon joining a clubhouse and after 12 weeks of attending. They compared this group’s performances with a baseline and 12 week measures from a group of 22 “veteran” clubhouse members (i.e., membership for more than 3 months). The new members made significantly greater improvements in task completion than the comparison group. The authors concluded that such results suggest that the clubhouse model may assist members to develop improved coping strategies, which translate into greater improvement in task performance (Yau et al., 2005).

Research Regarding the Effects of Clubhouses

Clubhouse research beyond the comparisons of vocational outcomes or cost analysis is extremely sparse. Searches of scholarly databases revealed several articles that
described services offered within clubhouses. Of these, Williams, Cain, Fredericks, and O’Shaughnessy (2006) outline a successful smoking cessation program instituted at one clubhouse and Nemens and Nicholson (2006) provide a similar outline for another clubhouse’s legal support services for parents with mental illness. Both of these articles provide support for other clubhouses to consider incorporating these services, but they do not provide details into clubhouses’ impact upon such programs (i.e., could these programs be equally successful in other settings).

Another descriptive investigation attempted to compile information regarding education programs targeting individuals with serious mental illness. Mowbray, Megivern, and Holter (2003) surveyed psychiatric rehabilitation programs across the U.S. about their educational offerings. In particular, the authors were looking for programs that provided post-high school support, such as college preparation classes and financial aid guidance. These programs are typically referred to as supported education. Through human-services database searches, the authors identified 103 supported education programs for individuals with psychiatric disabilities in the U.S. They contacted each program by telephone and conducted interviews of staff in an effort to gather information about the types of services provided at each program location. Mowbray et al. found that supported education programs are far more likely to be embedded within clubhouses than other programs of psychiatric rehabilitation. The authors asserted that clubhouses appear to be at the fore of the supported education movement. Such claims, however, need to be tempered by the limitations of the programs surveyed, as Mowbray et al. focused solely on programs identified as psychiatric rehabilitation. By doing so, Mowbray et al. may have excluded other programs that provide similar services within different programs.
(e.g., services provided by colleges’ offices of disabilities). Additionally, their descriptive design provided no input from members nor did it offer any information regarding quality of service or any outcome measures.

A more evaluative article regarding programs within clubhouses analyzed the effect of an in-house exercise program for members (Pelletier, Nguyen, Bradley, Johnsen, & McKay, 2005). This investigation tracked common markers of health and fitness (e.g., heart rate, body mass, weight) for 19 members at one clubhouse. The participants were adult volunteers recruited from one clubhouse in Massachusetts. After being medically cleared for a fitness program, the participants were included in a fitness program at a local gym. The program consisted of three 90 minute sessions over the course of 16 weeks. The fitness programs consisted of a mix of aerobic, flexibility, and strength training. Pre and post-intervention measurements of participants were collected, as well as satisfaction surveys. The authors found that the participants generally benefited from the program (e.g., blood pressure decreased from 124/76 to 118/74, body mass index decreased 33.32 to 32.60, heart rate slowed from 87 to 84), concluding that such programs would help a population that typically does not engage in fitness programs. Pelletier et al.’s conclusions seem intuitively appropriate, but the study relies on a small sample group (n = 19) and does not include a control group with which to compare results. The study demonstrates that clubhouse members can participate in fitness programs, but because of the study’s design it is impossible to determine if the clubhouse impacted the results.

Of the limited number of research efforts into the clubhouse model, Herman, Onaga, Pernice-Duca, Oh, and Ferguson’s (2005) and Mowbray, Lewandowski, Holter
and Bybee’s (2006) efforts reveal some facets as to what occurs within the centers. Herman et al.’s investigation undertook concept mapping as a way of understanding clubhouses’ staff and members’ sense of community. Their sample of 18 members and 18 staff from 10 different clubhouses were called together to work through three researcher guided activities: brainstorming, rating, and sorting. Brainstorming of ideas allowed members and staff, as distinct groups, to create lists of statements that described issues related to belongingness and community within the clubhouses. These statements were compiled for the two groups and each participant rated the importance (i.e., not at all important to extremely important) of each statement within their respective group’s list of statements. Afterward, the statements were printed to cards and participants were asked to sort the cards into groupings of related ideas (Herman et al., 2005).

Herman et al. (2005) identified concepts that emerged from the participants’ arrangements of cards. The sorted stacks were then analyzed using a two-dimensional non-metric multidimensional scaling program and hierarchical cluster analysis. Visual mappings of the clusters were created and the researchers created descriptive labels for these clusters. The researchers identified four concepts that were viewed as important to staff and members’ sense of community: (a) recovery, (b) social connection, (c) membership, and (d) tasks and roles. Herman et al. concluded that these concepts were congruent with the overarching goals of clubhouses and relate to the generally understood theories of community. Their strategy of mapping provides an interesting way of assessing how well clubhouses adhere to core principles and how well these principles relate to generalized concepts of empowerment. Despite the small sample size, the findings are encouraging and, importantly, the researchers took steps in including
participants in the research process. It would, however, have been even more interesting if the researchers included the participants in the final labeling of the clusters. This additional step would have allowed the researchers to assess how well clubhouse staff and members’ labels corresponded to the concepts found within the body of current psychiatric literature.

Alternately, Mowbray et al. (2006) investigated the clubhouse objective of empowerment. The authors devised a 3-pronged assessment (examining member’s involvement in operational decisions, support in problem solving skill development, and overall number of services provided) of whether their sample of clubhouses were indeed empowering their members to take a greater role in their lives and treatment. The researchers visited 43 clubhouses in Michigan to interview staff, observe activities, and administer surveys to members ($n = 31$). The data collected included measures of operational activities (e.g., hiring, budget issues, activity planning), members’ ratings of involvement in such activities, motivations for attendance (e.g., fellowship, mutual support, assistance from staff), and time spent doing various activities. Correlates were created, grouped, and processed through regression analysis to assess unique or co-contributing factors of each grouping (Mowbray et al., 2006).

Mowbray et al. (2006) found that clubhouse members did not engage in any significant level of participation in the general, day-to-day operations of the centers ($R^2 = .17$ for member involvement and operational decision making), but that members were encouraged to be involved and to follow through with making a wide array of their own treatment decisions ($R^2 = .48$). This, Mowbray et al. asserted, fulfills clubhouses goals of providing a setting that encourages member empowerment. The generalizability of their
findings is limited, as only 31 clubhouse members from the same region were surveyed, but their mixed findings are encouraging considering that many of the operational duties within clubhouses simply can not support multiple members (e.g., only one member is needed to run a café cash register) and as clubhouses continue to develop members may begin to play larger roles in governance duties.

Herman et al.’s (2005) and Mowbray et al.’s (2006) efforts are excellent steps toward increased understanding of what occurs within clubhouses. Both efforts created strategies to isolate and evaluate integral components within clubhouses. Significantly, Herman et al.’s design (i.e., brainstorming, rating, sorting) incorporates members’ involvement in defining what they, themselves, thought were important concepts and Mowbray et al.’s study examined one of psychiatric rehabilitation’s most important tenets (i.e., empowerment). Continued member involvement in research and a focus on the processes that occur within clubhouses are vital to understanding an increasingly utilized community mental health program.
Chapter 3

METHODOLOGY

In an effort to improve understanding of clubhouses, I conducted a qualitative inquiry into the clubhouse experience. By following an inductive path, I asked the members to provide the first-hand details that would help others to understand specifically how members view clubhouses. As such, a phenomenological design is the most appropriate means of capturing the so-called “essence” of what the clubhouse experience is for its members.

Phenomenology

The development of phenomenology as a science is often attributed to the early 20th century philosopher Husserl (Ashworth, 2003; Lichtman, 2006; Moustakas, 1994; Rice & Ezzy, 1993). In his writing and lectures, Husserl advocated that phenomenology is indeed a pure science, and that it holds as much value as the traditional empirical paradigms of understanding. Husserl’s assertion that phenomenology was integral in understanding the human experience was deeply influential upon subsequent philosophical treatises by authors such as Sartre and Heidegger (Lichtman, 2006).

During this time, many scholars began to question positivism’s notion that there existed singular truths, measurable only through observation (Ashworth, 2003). Instead, philosophers posited that there existed many realities, each shaped by the unique perceptions of individuals. As such, each person is his/her own “sense-maker,” constructing a personalized view of reality (Ashworth, 2003, p. 15). This notion, commonly referred to as constructivism, has over the years been written about extensively and has gained a wider acceptance. Currently, constructivism has come to
incorporate five basic tenets: (a) active agency, (b) order, (c) the self, (d) social-symbolic relatedness, and (e) lifespan development (Mahoney, 2004).

In essence, constructivism can be viewed as a lifelong, individualized, and recursive process of creating structures and meanings of the world around us (Mahoney, 2004). The concepts of individuals arranging, building structure, and giving meaning to ideas and events can be seen throughout history, and as early as the 6th century in ideas expressed by the philosopher and father of Taoism, Lao Tzu. Subsequently, kernels of constructivism can been found in the ideas expressed by Buddha, Kant, and, more recently, Piaget and Adler (Mahoney, 2004).

To capture such constructs in a phenomenological study, Creswell (1998) explains that investigators should look for the “essential, invariant structure or the central underlying meaning of the experience and emphasize outward appearance and inward consciousness” (p. 52). The task of giving meaning to experiences has clear ties to existential philosophy, but rather than writing about distant metaphysical concepts, phenomenology requires its writers to be present and in contact with the subjects of interest (Lichtman, 2006). By placing themselves in close quarters with their subjects, Lichtman explains that researchers then must follow a reductionist processes (i.e., the distillation of the essence from extraneous material) that incorporates hermeneutic translations of that which is studied (i.e., interpretation of experience into meaningful language).

Using qualitative methods for this research is appropriate for several reasons. These reasons align with the rationale put forth by Creswell (1998). Creswell suggests that qualitative inquiry is appropriate for research aimed at answering what or how
questions. This study is at its core asking “what is the essence of the clubhouse experience?” Additionally, Creswell asserts that qualitative inquiry is appropriate when an issue needs to be explored, in detail, and in its natural state. Since very little research has been completed into the processes of clubhouse, very little is understood about what actually occurs within them. In an effort to address this, this thorough exploration of how members view the clubhouse experience will add to the current body of knowledge.

Furthermore, the phenomenological approach to qualitative research is specifically designed to capture a phenomenon. According to Creswell (1998), phenomenology attempts to capture the “meaning of the lived experiences for several individuals about a concept or the phenomenon” (p. 51). This approach is often utilized in psychological, sociological, educational, and human services investigations. For this research, I was interested in documenting the lived clubhouse experience for several members and, through a method of reduction, creating a clear portrait of the clubhouse phenomenon.

Recruitment

As previously noted, I had an established professional relationship with some local clubhouse members and staff. In considering such preexisting relationships, Creswell (1998) states that an established rapport may be a boon to the recruitment process, especially if the phenomenon being studied is well guarded from “outsiders.” Clubhouses are open community centers, but due to the widespread stigmatization of people with mental illnesses, individuals are sometimes reluctant to discuss details of their lives. Having professional ties with some of its members may have aided in recruitment.
The local clubhouse, however, is homogeneously White and relatively well served by our rural mental health system. Rice and Ezzy (1999) forewarn that problems such as homogeneous samples can arise when researchers simply rely on easily accessible samples. To avoid such confounds, they stress that investigators should make efforts to tap into a variety of appropriate sources. As such, I included members from a clubhouse located in an urban and traditionally underserved area. To do this, I identified several other clubhouses listed on the ICCD’s on-line directory of accredited sites and noted several clubhouses that were reasonably close to my home base. Additionally, the local clubhouse is fairly new (i.e., fewer than six years of service) and I wanted to include a clubhouse that had a longer history of services. This additional criterion helped narrow my list of potential secondary sites. From my list of reasonably close, well-established, and urban clubhouses, I contacted one and solicited permission to include their site in my study. My request was received enthusiastically, but approval was contingent upon a formal application and review. I successfully completed their additional review and was invited to start my investigation.

For both of the chosen clubhouses, the process of engagement was similar. I contacted the appropriate agents, explained the project, and asked permission to recruit for this project. Both clubhouses were interested in participating but, as previously noted, the urban clubhouse requested an additional formal application and review of my research proposal. To start the recruitment process, I forwarded flyers to both clubhouses that briefly explained the project (see Appendix B) and provided details as to how interested individuals could contact me. The flyers included an explanation that
participants would be expected to meet with me for a one hour interview, for which they would receive monetary compensation for their time (a $10 participation award).

**Sampling**

Unlike quantitative methods, qualitative research is not driven by finding a statistically representative sample that may be generalized to a larger population (Creswell, 1998; Rice & Ezzy, 1999). Instead, qualitative sampling strategies emphasize the purposeful uncovering of information-rich sources that can provide illuminating details regarding their experiences (Creswell, 1998; Moustakas, 1994). In designing my phenomenological study, I utilized convenience, criterion, and snowball sampling strategies.

Convenience sampling, as the name implies, is simply based upon enrolling those who are easiest to include (Rice & Ezzy, 1999). Having worked many years as a case manager and counselor within the local community mental health system, I was familiar with this region’s clubhouse and had informally discussed this research project with its staff and members. Both staff and members greeted my research interests enthusiastically. Such ease of access, according to Creswell (1998), is an acceptable sampling strategy when the phenomenon being studied is particularly esoteric or well guarded. Due to the widespread stigmatization of individuals with mental illness and confidentiality restrictions imposed by mental health service providers, the sample sought for this study could be considered a well-guarded population.

Alternately, criterion sampling, according to Rice and Ezzy (1999), is based upon adhering to a predetermined set of characteristics that participants must fulfill. For this study, I kept my criteria for inclusion fairly simple. My sample was limited to individuals
who were 18 years old or more, who had been clubhouse members for more than 2 months, and who were verbally expressive. The latter criterion was of considerable importance since qualitative investigations are built upon the details proffered by participants. Furthermore, its inclusion was necessary, as some individuals’ abilities to express themselves could have been hampered by symptoms related to their illnesses. According to the *DSM-IV-TR* (APA, 2000), conditions such as schizophrenia, major depression, and bipolar disorder can include disruptive symptoms like alogia or disorganized speech, which could possibly interfere with an individual’s ability to express his or herself.

In order to ensure quality interviews, I asked the staff members to consider the aforementioned inclusion criteria and to help guide appropriate members towards interviews. This step was included as a means to screen potential participants who may be experiencing mental health symptoms that would interfere with their ability to understand and complete the interview. Staff members did not suggest that any of the interested members were inappropriate for an interview.

As an additional screening effort, I initiated a brief, informal “ice-breaker” interview. This interview had a two-fold purpose: to put the interviewees at ease and to assess their level of expressiveness. The ice-breaker interview consisted of topical, open-ended questions that allowed potential participants the opportunity to demonstrate their speaking skills. All of the members who were scheduled for interviews fulfilled all of the criteria for inclusion.

Lastly, snowball sampling encompasses utilizing the internal established networks as referral sources (Creswell, 1998; Rice & Ezzy, 1999). This method typically follows a
word-of-mouth chain, where one participant refers other potential participants to the investigator. Since clubhouses are built upon the social interconnectedness of its members, snowball sampling proved to be effective in generating additional participants. Interestingly, both of the clubhouses positioned me in fishbowl rooms (i.e., rooms with windows facing other rooms and hallways). During my interviews, it was apparent that my guest appearances were creating discussions amongst the members, which aided in the snowballing process. Additionally, several of the interviews concluded with participants stating that they would encourage their peers to participate.

Data Collection

Once interested members contacted me, I inquired as to where they would prefer to meet for the interview. All but one participant requested meeting at their respective clubhouses. For the individual who did not want to meet within his clubhouse, we agreed to meet in an on-campus office. For the individuals who wanted to meet within the clubhouses, I contacted the respective clubhouses’ staff to schedule an appropriate time to meet with the participant. Staff members at both clubhouses were very accommodating, allowing me the use of semi-private areas of the clubhouse for uninterrupted interviews. Unfortunately, two of the interested participants did not arrive for their scheduled interviews. In these instances, the clubhouse staff were able to find last minute substitutes. Due to the time restrictions and limited resources of this project, I did not attempt to reschedule the missed appointments.

As previously noted, I took several minutes to engage participants in some general, topical “small talk.” This small talk allowed me to assess suitability for this project while allowing participants some time to become more comfortable with me and
the interview process. Two participants expressed some minor discomfort and fears that they would answer questions “wrong.” All of the participants were assured that there were no wrong answers and, overall, each participant appeared comfortable with the interview process. All of the participants completed the interviews without interruption. Several of the participants were extremely enthusiastic about their role in this research. Additionally, most of the participants politely expressed gratitude for having an interested audience.

The formal interview process was comprised of (a) a review of the purpose of the study, (b) procedural explanations, (c) review of confidentiality and its limits, (d) obtainment of signature for informed consent (see Appendix C), (e) choice of pseudonym, (f) collection of basic demographic information, and (g) and the interview. All participants were encouraged to provide as much detail as possible when describing their experiences. Additionally, they were informed that they could ask me any questions about the study, choose to not answer questions, or end the interview at any time.

The interview itself was loosely structured around 12 open-ended questions (see Appendix D) that were designed to elicit details regarding the interviewees’ experiences within the clubhouse. These questions were based upon my preconceived notions of what may or may not happen within a clubhouse. Additionally, my academic advisor assisted in clarifying some confusing language within the questions. Overall, the questions were created with the hopes that participants would freely expand upon the general directions laid within each. In an effort to remedy question bias, each interview contained multiple offers to discuss anything relevant to their clubhouse experience. Moreover, having training and work experience as a journalist, counselor, and researcher (all of which rely
on the interview process), I was comfortable with asking questions and probing different topics.

All of the interviews were recorded with a portable cassette recorder. The tape recordings were then transcribed verbatim by myself. The interviews yielded over 300 pages of data. Importantly, the transcription process (i.e., repeatedly listening, typing, rewinding, and proofreading) provided an invaluable additional level of immersion into the data.

After transcription, the reports were mailed to the respective interviewees for verification of content (see Appendix D). This verification process allowed participants an opportunity to review the data to ensure that what they stated was being accurately reported in the transcripts. Additionally, it offered participants the option to revise, delete, or add content. This option was included to allow a chance to remedy any misstatements or lapses in memory. None of the participants asked for any revisions to their respective transcripts. Throughout the investigative process, confidentiality was of the utmost importance and every effort was taken to ensure that the participants’ identities were protected. All documents, including field recordings, transcripts, and notes, utilized the self-selected participants’ pseudonyms.

Sample Size

Rice and Ezzy (1999) unapologetically provide an amorphous explanation as to how large of a sample should be examined in qualitative inquiries. They explain that, “the sample size is large enough when it can support the desired analyses” (p. 46). Creswell (1998), however, is more direct in his recommendations, stating that a phenomenological investigation can have up to 10 participants. Slightly more precise is Smith and Osborn’s
(2003) statement that five or six participants is a “reasonable sample size” (p. 54). To ensure coverage, I had initially planned to interview 10-15 members, with the final sample size dependent on member interest, quality of data, and resources available (i.e., time and money).

After completing eight interviews, it became apparent that members were quite capable of providing quality interviews. All of the initial interviewees provided a great deal of details regarding their experiences. Many of the same themes began to emerge and I was confident that their responses would easily answer this projects research question. I did, however, continue to interview members to ensure saturation of topics. In total, I interviewed 14 members from two separate clubhouses (10 from the rural clubhouse and 4 from the urban clubhouse). The discrepancy in distribution is a result of limited funding available to cover travel expenses to the urban clubhouse.

Analysis of the Data

For analysis of the interview transcriptions, I followed Creswell’s (1998) outline of data management. Creswell provides a practical guide for completing such endeavors. His step-by-step recommendations draw heavily from Moustakas’ (1994) influential, yet highly theoretical, work regarding phenomenology. Creswell recommends that investigators first create their own description of how they view the phenomenon being studied and then make every effort to suspend these preformed notions. Creswell refers to this as bracketing and suggests this procedure as a means toward reducing the influence of one’s own value judgments on the data.

Prior to interviewing participants, I created a written description of what I thought the clubhouse experience was. My pre-investigation description of the clubhouse
included a highly complementary list of adjectives about the services. This list includes words such as warm, empathic, supportive, helpful, caring, and encouraging. These words were used to describe the types of services, staff, and members. Additionally, my pre-investigation understanding was that clubhouses primarily provide social, vocational, and (at some locations) housing services. All of my pre-research views were shaped by academic pursuits and, more profoundly, by my direct and indirect work with the local clubhouse and its members. During the analysis of the data, I continually reflected upon my bracketed notions and actively considered whether my findings were supported by the data or merely reflections of what I had expected to find. All efforts were made to remain cognizant of my own biases, as I attempted to illuminate what was truly in the data.

After conducting interviews, Creswell (1998) recommends that researchers immerse themselves into the data, repeatedly reading it and identifying significant statements. Creswell refers to this as “horizontalization of the data” (p. 147). From my interviews, I read through each transcripts several times, identifying statements that offered descriptive details of the clubhouse experience. I manually highlighted all statements that provided significant information and continually made notes about any pertinent details. Using a word processor, a compilation of all of the significant statements was created.

After compiling all of the significant statements, I continued reviewing the data and made notes within the documents margins regarding potential themes or other relevant details. After careful consideration of these notes, I identified the overarching themes found within the transcripts. I identified two major themes that contained several sub themes. To help guide the process, I created a visual diagram to represent the themes
and their relationship (see Appendix E). Again, using a word processor, I created
documents representing each distinct sub theme and coded each significant statement into
its corresponding sub theme. This coding of the meaning units areis the foundation for
creating what Creswell (1998) describes as the “textural description” (p. 150) of the
phenomenon being studied.

The meaning units were then arranged in a manner that illuminated what occurred
within the participants’ experiences of the clubhouses. To do this, I created summarized
lists of the key elements from each statement and eliminated redundancies (see Appendix
F). Next, I followed Creswell’s (1998) recommendation of reflecting upon my own
preconceived descriptions of the experience and, through a process of “imaginative
variation” (i.e., viewing the phenomenon through all frames of references and from each
interviewee’s perspectives) I constructed a written description of the experience. In doing
this, I tried to envision how each participant viewed the subject at hand as a person,
client, member, volunteer, employee, friend, or whatever roles that individual spoke of.
After doing such for each meaning unit, an overall composite account of the experience
was created.

Rigor, Standards, and Verification

Validity and reliability are generally accepted as concepts that ask the respective
questions: Is the measurement truly measuring what it purports? And, can the
measurements be found consistently? Within quantitative studies, these issues are
important markers of a study’s worthiness (Rice & Ezzy, 1999). Qualitative research,
however, does not typically rely on these terms. This is not to say that qualitative
research abandons issues of quality and worthiness. Instead, Rice and Ezzy argue that the
concept of rigor can appropriately capture the issues addressed within quantitative research’s measures of validity and reliability. Rigor, according to Rice and Ezzy, indicates how well the information yielded represents the observed reality of the subject. Such explanations, however, are somewhat limiting, as one could argue that a constructivist view of reality is highly subjective (Rice & Ezzy, 1999).

Others, such as Creswell (1998) and Lincoln (1995) highlight that such qualitative issues have come under considerable scrutiny and that the methodological approaches continue to evolve. The central concern, according to Creswell, is “How do we know that the qualitative study is believable, accurate, and ‘right’?” (p. 193). Creswell suggests that investigators need to adhere to the emerging standards of practice and undertake the needed steps for verification. Notably, Creswell identified eight commonly employed exploratory procedures that increase the trustworthiness of qualitative investigations. His compilation includes practices such as prolonged engagement, negative case analysis, and external audits. Creswell (1998) recommends that researchers enact at least two different methods.

From Creswell’s (1998) list, I undertook five methods that provided rigor and verification: (a) clarifying researcher bias, (b) member checks, (c) rich descriptions, (d) triangulation, and (d) peer review. As previously noted, I was familiar with clubhouse services and throughout this process, I continually strove to clarify my expectations of this research. Member checks included written consultation with the interviewee’s at two points during the research. This included my mailing the typed products back to the participants, asking for their review of the transcripts for accuracy (see Appendix E) and several reviews of the final interpretations of the data (see Appendix F).
For the transcript reviews, I asked participants to contact me directly (i.e., by phone, mail, or email) with any reports of discrepancies or additional considerations. As noted previously, participants did not make any changes to their written transcripts.

Secondly, I met with four of the participants for individual reviews of my analysis of the data. This included reviews of the process of data analysis and a written full descriptive statement that summarizes the clubhouse experience. This allowed the participants an opportunity to evaluate whether the findings appropriately reflected their experiences. All of these participants stated that the description of the clubhouse experience accurately reflected their experience.

Furthermore, I triangulated my findings with research or theories that apply to the themes that emerged from the data. None of the issues that emerged were incongruent with what has been widely accepted within mental health treatment (e.g., unconditional positive regard is helpful in building strong working alliances [Rogers, 1951]; employment helps individuals self-esteem [Szymanski & Parker, 1996]).

Lastly, I included a peer review of the data and the process with a certified rehabilitation counselor who specializes in vocational issues for individuals with serious mental illness. During regular consultations with this peer, I presented sections of raw data, my notes, and definitions of themes. Our discussions typically addressed whether my interpretations of the data appeared to coalesce with what participants presented and whether significant statements appeared to be appropriately coded. The peer reviewer helped guide the process toward themes that appeared to be organically linked to the data. These discussions were reassuring and helpful to the process. Creswell (1998) notes that
such debriefing is important, in that peers can “keep the researcher honest” (p. 202) by scrutinizing methods, meaning, and interpretation.

Generalizability has come to denote how well the conclusions reached regarding a sample may be representative of the larger population. Again, such concepts are more appropriately applied to quantitative efforts (Smith & Osborn, 2003). Alternatively, phenomenological inquires attempt to understand the essence of a particular experience, which ultimately may not be representative of all similar experiences. This, as Smith and Osborn note, does not mean that there is no generalizability within qualitative research. They posit that if rigorous methods are employed and subsequent repetitions of similar results are found, a theoretical generalizability will gradually emerge.

Critics of qualitative research contend that such empirical shortcomings render its utility questionable, but others contend that applying quantitative standards to qualitative efforts is simply inappropriate (Dixon-Woods, Shaw, Agarwal, & Smith, 2004; Yardley, 2000; Smith & Osborn, 2003). As such, my efforts were not driven by quantitative expectations regarding validity, reliability, and generalizability. For this project, I adhered to the current standards of qualitative inquiry and remained rigorous in my effort to accurately capture the essence of the clubhouse experience. Through theses efforts, clubhouse members were afforded the opportunity to accurately describe exactly what the clubhouse experience was for them.
Chapter 4

FINDINGS

Introduction

The purpose of this investigation was to better understand the clubhouse experience through the words of its members. Through a series of hour-long interviews, I documented the stories of 14 clubhouse members. From these interviews, I followed the methodological precepts of qualitative research. This entailed transcribing the interviews, reading and re-reading the transcripts, coding significant statements, identifying common themes within transcripts, and creating a distilled representation of the clubhouse experience.

Participant Information

At the start of each interview, I gathered basic demographic information from the participants. This information included: (a) age, (b) gender, (c) ethnicity, (d) relationship status, (e) years with mental illness, and (f) years as a member of a clubhouse. This information was collected in an effort to describe the interviewees and provide some context for the material gathered in the interview. This framing of the material adds to the overall understanding of the interviewees’ perspectives (e.g., if all of the interviewees were new to clubhouse, their experiences may be colored by the novelty of the services).

Individuals’ specific diagnoses were not recorded as part of the demographic statistics. This decision was guided by an important philosophical premise of clubhouses. At their core, clubhouses are strength-based institutions that de-emphasize illness. This concept is seen as integral in moving people away from thinking of themselves and others as categories or labels (e.g., those “schizophrenics”). Since the interviews were planned
to be held within clubhouses, I felt that it would not be in the spirit of clubhouses to initiate the interviews with inquiries counter to the clubhouse philosophy. Furthermore, it is well-established that clubhouses serve individuals with serious mental illness and, as such, it is reasonable to assume that the individuals that I interviewed did indeed have such illnesses. Moreover, I was not interested in analysis of the perceptions from different diagnostic categories. I was instead trying to capture the whole experience of clubhouse, regardless of diagnoses. As noted previously, I did feel that it was important to include length of illness (regardless of diagnosis) to provide some context.

The participants in this study represented a wide range of life and mental health treatment experiences. Ethnicity and relationship status, however, were fairly homogeneous, with 11 people being White (two people being African American and one person of mixed descent) and 12 people self-identified as single (one person reported being widowed and another person reported being divorced). Their ages ranged from 21-63 years old, with a median age of 42. Of these, the majority (seven participants) were in their 40s, three in their 20s, two in their 30s, and two in their early 60s. The gender demographic was evenly split, with 7 females and 7 males.

All but two the participants reported that they have had a mental illness since early adulthood. One person reported having an early (i.e., pre-teens) onset of mental illness, while one person reported a late (i.e., middle aged) onset. The range of years with a mental illness was reported from 5-53 years, with 22 years of a mental illness as the mean. Lastly, the average length of membership for the participants was just over 5.5 years, with a range from 3 months to 26 years. The majority of the participants had 5 or
fewer year of membership, while two participants had over 10 years, and two others had
over 20 years of membership in a clubhouse.

Participants’ Receptiveness to this Research Effort

It should be noted that the majority of the interviewees reported a great deal of
enthusiasm toward this research project. I had no difficulties in finding willing
participants and I limited the number of participants solely due to time and financial
constraints. I am certain that I could have easily recruited many more interested
participants.

The decision to offer what I thought would be a fair monetary compensation ($10)
for participation was given to all who were interviewed, but several of the interviewees
explained that they were not motivated by the money. Instead, they reported they were
hoping that any additional attention to clubhouse would generate an expansion in its
utilization or that their participation would help the general public gain a better
understanding of their experiences and of mental illness in general. At the conclusion of
one interview, the participant expressed her gratitude for the interview session and
explained, “I think the general public needs to look at people with mental illness and
realize that, okay, just because they have it [mental illness], that doesn’t mean that they
should be afraid of them.”

At the close of nearly all of the interviews, the participants thanked me “for
listening,” and expressed their appreciation for my interest in their experiences and the
clubhouse model. One participant, in an effort to convey his gratitude for my calling,
attempted to refuse payment, stating, “You don’t need to pay me for this.” Still, another
participant quipped, “I can’t believe you’re paying me. I should be paying you.” As a
researcher, I was thoroughly impressed by the participants’ attitudes and enthusiasm for being included in this project.

**Significant Statements and Emerging Themes**

During the interview process, several distinct themes began to emerge. During the transcription process and upon reading and rereading the transcripts, the themes became increasingly evident. After highlighting and compiling all significant statements, I began to visually conceptualize how the statements appeared. Organizing and presenting the themes, however, was somewhat of a challenge. Several different tacks could have been taken, each affecting how the results would be received by the reader. Importantly, I wanted to portray the significant statements in an easily comprehended image (see Figure 1) while attempting to include the entire range of significant statements. Under these considerations, the participants’ statements seemed to naturally fall into either positive statements or negative statements about clubhouse. Positive statements were statements that highlighted how the clubhouse experience had been enjoyable or beneficial to the participant. Conversely, negative statements highlighted how the clubhouse experience had been unpleasant or harmful to the participant.

This arrangement of themes seemed to be the most easily understood while allowing for the inclusion of some of the less obvious themes. Alternate arrangements could have included groupings along the themes of empowerment, peer support, sense of community, and such. This, however, created awkward or slightly inaccurate antithesis themes of disempowerment, lack of peer support, lack of a sense of community, and such. The decision to utilize the themes along a positive/negative division seemed to keep
true to the spirit of the participants’ perceptions of their respective experiences while

giving accurate weight to both helpful and unhelpful interactions with others.

This division of statements was then broken into smaller units representing the
sub-themes within the statements. Importantly, by arranging the significant statements in
positive and negative divisions, the reader can easily see that the subsequent sub-themes
demonstrate an overwhelmingly positive view of the clubhouse. The sub-theme topics
addressed either (a) the people at clubhouse (i.e., staff or members), (b) the services
offered (i.e., in-house duties, temporary employment positions outside of clubhouse, or
other activities), or (c) the effects of clubhouse upon behaviors or thoughts and feelings
of the participants. For each subsequent sub-theme unit, I created a list of descriptions
that shape the themes. Each theme will be addressed individually, presented both in the
text and in table form with representative quotes.
Figure 1

A visual depiction of how significant statements were coded into separate units.
Negative Statements

As previously noted, the positive statements offered by participants far outweighed the negative statements. Because there were so few negative statements, it was initially difficult to recognize individual statements as being a part of a theme. Some of the negative experiences appeared to be isolated incidents, but further consideration revealed a theme of unhelpful responses and distracting behaviors of both members and staff, and perceived shortcomings of clubhouses. What follows is an explanation of the negative themes that emerged. This includes themes regarding negative experiences with others and with the services,

Theme of Poor Member-to-Member Support

This theme was by far the weakest of all identified themes, but several members noted that member-to-member communication could, at times, be poor (see Table 1). Of the 14 interviewees, only three described such difficulties. The most vocal of these participants was a woman who reported that the mutual support found within the clubhouse did not translate into member-to-member support outside of the clubhouse. She stated, “I’ve known a lot of these people a lot of years. I’ve reached out a lot. Ehhhhh [sighs and laughs incredulously]… I wish there were more [support]… What I mean is outside the clubhouse… in the clubhouse, they’re really nice to me.”

Table 1

<table>
<thead>
<tr>
<th>Statements Regarding Poor Member-to-member Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>At the new clubhouse, they weren’t very welcoming</td>
</tr>
<tr>
<td>Another member unfairly reported me as being suicidal when I wasn’t</td>
</tr>
</tbody>
</table>
Sometimes I think the other members don’t like me – I reach out, but I get no response

There’s not a lot of member-to-member support outside of the clubhouse

Note. The statements presented in the table represent composite statements created from the participants’ words, after all redundancies had been eliminated.

Theme of Poor Quality of Staff

Similar to the previous theme, the low quality of staff theme was weak. Several members, however, identified incidents when a staff member treated them unfairly or unkindly (see Table 2). In each of these reports, however, interviewees were overwhelmingly satisfied with staff despite “one bad apple.” This theme is of note, however, because two participants were recalling incidents that occurred over 10 years ago, indicating that such unprofessional behavior has a lasting impact on members. One such example came from the participant who had the longest membership in a clubhouse. He stated:

Some staff bothered me in the early years. Well, I thought that, uh, the way they treated me was, uh, that they were trying to, that they were making fun of me.

There were a couple. One was Debbie. She was on the clerical unit. She was staff. And I always got the feeling that she was making fun of me – the way she talked to me… if you’re schizophrenic, you know, and you’re hearing voices and things like that… so you don’t know if your take on these people is really true. But uh, I’m pretty sure that they didn’t like me.

Table 2

Statements Regarding Poor Quality of Staff

I could tell that some staff didn’t like me
Some staff members were rude and made fun of us

They were overly enthused about my attendance – it was kind of off-putting

Note. The statements presented in the table represent composite statements created from the participants’ words, after all redundancies had been eliminated.

Theme of Poor Quality of Services

Similar to the previous negative themes, the corresponding positive theme for quality of services was much stronger. The negative statements regarding the quality of services were split between three issues: dissatisfaction with the vocational services (both in-house work duties and Transitional Employment Placements [TEP]), the amount of in-house counseling, and a failure to properly promote the services (see Table 3). Several of the participants reported that the in-house work assignments, at times, were below their abilities or simply unappealing. One member described some of the work as “meaningless,” while another explained:

Well, the one part of clubhouse I don’t like is the cleaning. I know it’s a terrible thing to say. I mean, I’m not a, um, [sighs and pauses] I’m not an Oscar Madison or Felix Unger, in the cleaning set. And sometimes the cleaning part gets redundant. So a lot of times I’ll only stay in the morning [and leave before the cleaning chores begin].

Other participants reported that there were not enough TEP employment opportunities. TEPs are an important component for clubhouses where members make the transition from in-house work to “real world” employment. One member explained:

We need more TEP, temporary employment placements programs – more job placements. Because, I know that there are a lot of people that come here and are quite functional – that have just been here for years. Being here at clubhouse,
doing work. It would be nice to see them somewhere else, you know, making the
next step.

This complacency to stay within the clubhouse was viewed as unhelpful for the members
and the program. Additionally, some people stated that the work-ordered day was too
restrictive. Having to continually maintain the program detracted from socialization and
peer-to-peer support. According to one member, the need to be “doing things” keeps
individuals who are “lower functioning” from attending. He explained:

I wish there was a little bit more lenience toward… uh, self, doing whatever the F
you want… I see people come in, and if they’re very low functionality. I think,
you know, the opportunity for someone like me, who’s very high functioning, is
to be able to go and sit, and just chat with that person for a half-hour – if that’s all
they’re in here for, socialization. And I think that’s really missing here at this
clubhouse. I remember that there used to be lounge chairs. And they got rid of
them… they got rid of the comfy, cushy chairs. And now we’re a work-ordered
environment.

Most of the participants, however, stated that they liked the structure of the work-
ordered day. Interestingly, many people stated that they also liked that the clubhouse does
not focus on illness, yet many of the same individuals reported wanting more mental
health counseling at clubhouse. One participant noted that he could have benefited from
counseling after a particularly traumatic staff firing, stating that, “…I just didn’t feel like
I got taken care of properly that way.” These concerns were, however, often tempered by
a recognition that counseling services were available elsewhere. The lack of in-house
counseling, one member explained, is:
…where the shortfall would be. Because we have a lot of issues, and things like that. Clubhouse cannot be all of that to you. Clubhouse fills a particular niche that isn’t being filled elsewhere in society. I mean, you’ve got a place to come, you’ve got purpose, you’ve got value.

Others expressed some dissatisfaction with how too few people know about clubhouse and how more people could be served by it. Two members suggested that more should be done to promote clubhouse. One person reported that he would have joined years earlier had he known about it. He said, “I didn’t even know… the model ran for, like, 40 years already. I mean, [pause] my case manager hardly knows anything about that. Um, it doesn’t have a lot of, um… What’s the right word for it? Visibility. It doesn’t.”

Table 3

<table>
<thead>
<tr>
<th>Statements Regarding Poor Quality of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>There aren’t enough employment opportunities</td>
</tr>
<tr>
<td>They don’t provide enough meaningful work and activities</td>
</tr>
<tr>
<td>There’s too much busy work and cleaning duties</td>
</tr>
<tr>
<td>They don’t always include us in the work activities completed by staff</td>
</tr>
<tr>
<td>They don’t focus enough on getting us involved in advocacy issues</td>
</tr>
<tr>
<td>The work-ordered day is too structured. There needs to be more socialization time</td>
</tr>
<tr>
<td>They don’t have enough opportunities for individuals functioning at lower skill levels</td>
</tr>
<tr>
<td>There should be more counseling services – especially during difficult times</td>
</tr>
</tbody>
</table>
They need to better promote the program – let more people know about the services

*Note.* The statements presented in the table represent composite statements created from the participants’ words, after all redundancies had been eliminated.

### Positive Statements

All of the interviewees spoke positively about their clubhouse experiences.

Several people cited it as being the key factor in maintaining their mental health stability. At times, some individuals had some difficulties in explaining what it was that was so helpful, often offering statements such as, “I don’t know, it just makes me feel good.” Indeed, this notion was the most frequently repeated sentiment. The common difficulties in explaining precisely what was helpful may stem from the complexity of the challenges that many of the interviewees have faced combined with finding a place where a variety of their unmet needs are finally fulfilled. Many of the participants spoke of years of difficulties where they were often mistreated and infantilized. Upon joining clubhouse, many reported that they just *sensed* that clubhouse was *right*. When pressed further to explain how clubhouse was “right,” the interviewees described a place that was fulfilling many of their deepest needs. Often highlighted was the reported sense of inclusion – finally finding a place where they felt welcomed and unburdened by the stigma that commonly weighed them down. When asked to describe his clubhouse experience, one participant repeatedly enthused, “Ahhh, I wouldn’t know where to start with that. Man, this place rocks!”

What follows is a presentation of the positive themes that emerged from the interviews. This includes the sub themes regarding positive experience with others, with the services, and the effects of these positive experiences.
Theme of Excellent Peer Support

The theme of excellent peer support was one of the strongest themes. Participants offered a variety of examples explaining how their peers have helped them (see Table 4). The ideas of support, encouragement, and empathy were repeated in a number of different ways, and all of the interviewees touched upon these concepts. Interestingly, many of the participants stated that there was something unique about the level of understanding found within clubhouse. In comparing clubhouse to other programs, one member explained that the member-to-member support was stronger,

…given the fact that we have mental illnesses. It will be [stronger] here than anywhere else. Because, if I say I have a mental illness, if I’m try to connect with someone who doesn’t have a mental illness at a job or something, they will have no clue as to what I’m talking about half the time. And here, it’s like, “Okay, I understand what’s going on.” So I think at that level it is different… that’s big – especially when you’re talking about stuff like your TV’s talking to you or, you know [laughs]. That’s just one example. And I know so many people who have had that experience. I don’t know many people who don’t have quote/unquote mental illness that had the television talk to them. So, that’s kind of… just saying that, it sounds like, “Alright, this guys TV talks to him,” you know. But um, I know a lot of people who have had it happen to them. And when they say it to me, I understand totally what they’re talking about.

Participants reported that this level of understanding was crucial in creating a caring, accepting environment where exceptionally strong bonds are formed. A participant explained:
It’s a friendship with people who might not have the same diagnosis that you have, might not be going through the *exact* same things that you have, but in general, we have all experienced, unfortunately, some of the same pain. Like being rejected, not being understood, not believed, um, med changes, doctor changes, changes in your support people. Just a commonality. A commonality… here, we can say, “I know how you feel.” Or at least I can have empathy at what you’re going through and I’ll be there to support you, call me at home, or sit down and talk with me now.

Several members described the friendships as being stronger than family ties. A member stated, “Many of us have families that do not understand and don’t want to be bothered. Many of us. Here, there’s a real understanding.” Another participant stated that she viewed clubhouse as being “Like my real family should be… because of my real family being, like, a dysfunctional family.” She went on to explain that,

It all goes back to the respect that [other members] give you and the feelings that they put towards you. Like, they respect you and they understand you and, they talk to me like an adult. Not like a 6 year old [laughs]. Which is what usually happens at home.

The participants reported that the respect and encouragement received from other members contributed to the overall positive energy within the clubhouse. A member described this as:

You don’t feel like someone is going to say, “She doesn’t know what she’s doing. She doesn’t know her job.” There’s just not that attitude here. So, I guess part of it is the very positive attitude – that you’re not wrong, you’re not dumb, you’re not
incapable. Um, very understanding, and that’s part of the clubhouse model. And
to say like, “Good for you. I haven’t seen you do that” or “You really took charge
of the house, thank you,” or “We were all so busy and I saw you just running the
whole clerical unit.” And I know it’s not just words. It’s very heartfeltly meant.

Some of the participants provided descriptions of activities that are not commonly
seen within other services for individuals with serious mental illness. Most notably,
several members reported being highly appreciative of all the “hugs and kisses” shared
between members. The overwhelmingly positive descriptions of the members led me to
ask one participant if her peers were truly as supportive as she was presenting them to be.
She responded:

This is coming from here [as she patted her chest]. In fact I, if I could I would
spend my weekends here too. If I could. It’s that positive. [Tearfully] Because
I’ve had a lot of negative in my life. And that’s what gets me down, but, but
however down I am these people just give me a yank up by my bootstraps. But,
then its okay to say, “Okay, I have a problem.”… But, they just give me hope to
get through it… they’re trying to help me get my self respect back, my dignity,
my self esteem back.

Table 4

Positive Statements Describing the Members

They’re willing to help and support you

They’re very giving. They would lend you the shirt off their backs

They’re encouraging and very patient

People are friendlier here – there’s a lot of fellowship
Making friends here is like therapy – I’ve made some wonderful friends here

They care deeply about me

No one pressures you, people let you do what needs to be done

The people here are smart, funny, and can be successful despite their illness

Here, we’re all equals

The people here are like family – even better than family

Together we form a strong base – a united front to fight stigma

They truly understand me and my illness – there’s a lot of empathy

They accept me for who I am

There’s a lot of respect for each other

Everyone seems to have a positive attitude here

When I’m down, the people here become uplifting

There are a lot of compliments given – and they’re heartfelt

The people here are very open and honest

Their hugs and kisses, and joking around are really helpful

I can trust the people here

They treat me like I’m a capable and competent adult

They’ve helped me stretch my wings

The members are what make the clubhouse effective

Note. The statements presented in the table represent composite statements created from the participants’ words, after all redundancies had been eliminated.

Theme of Quality Staff

All of the participants stated that the staff contributed positively to their clubhouse experience. As previously noted, there were a few reports of staff members negatively
affecting participants’ clubhouse experiences, but comments describing staff were overwhelmingly positive. Many of the comments reflected core skills that human service workers are trained in (e.g., listening, empathy), but the participants emphasized that the staff are more invested in the members than staff at other programs. One participant explained:

I think that the involvement of the generalists here is much greater than some of the other job and rehabilitation programs. I would say that the generalists here are more involved… In the initial phases, it’s more helpful. Their patient encouragement [of us].

Another interviewee described his first day at clubhouse and how he views staff as more than mental health workers: “I met with the wonderful staff here… they welcomed me with open arms. It’s almost like a family, rather than a workplace.”

This notion of family was reiterated by several participants. It may stem from the participants feeling as if the staff members genuinely care about them. One participant reported that the staff’s education and training benefited them, but sensed a greater commitment from them. He stated:

These people, the staff, have dropped their other jobs to help people like us and I think that that’s wonderful. Because they didn’t have to help us. They could get regular jobs. But, yet they took the time to help us realize our potential and dreams… [They] don’t have to come to work here. But they help us in most important ways. And that’s what makes me feel good – knowing that somebody wants to help me… Okay – they pay them, but they do care. I mean, it’s not an act.
Another member further explained, “They’re not phony. They’re just good kind people. They only hire people who care about people.” And in acknowledging the often poor pay rates for human service workers, she stated, “People don’t come here for money reasons – because if they came here for the money [laughing] they’d quit!”

One of the most senior of the participants recounted how one staff member has been supportive to him over the years – well beyond work duties:

Well, there was one women on the clerical unit, who was obviously staff. Her name was Mary, she’s no longer here. And she put so much effort into making me feel at home, do work. Till this day, she takes me out to lunch for my birthday. Even though she’s no longer here. I’ve kept in touch with her. She’s married. She’s… a very nice person. Right away, I knew that she was sort of, like, a support and a very nice person.

Importantly, members reported their appreciation that the staff are willing to do the same duties that members do. Describing staff, one interviewee explained:

… everybody here encourages you to get involved. They work side-by-side with you. And they respect you. There’s nobody who’s better than anybody else, there’s nobody that’s above anybody else. And it’s more like one-to-one, yeah. And, I enjoy that sort of personal touch. And I feel that I’m loved here and that people care about me.

| Table 5 |

*Positive Statements Describing the Staff*

They’re very busy all the time, it seems like a challenging job, yet they remain positive
They’re right there with you – working side-by-side with you, helping you
The staff here are more involved with helping people than at other programs
They’re well-trained and well-educated – especially regarding mental health issues
They lead by example – it’s inspiring
The staff are wonderful – they’re friendly and welcome you with open arms
They’re really encouraging – they want to see us succeed
They’re flexible – with a wide range of abilities
They work here because they truly care about us
They’re true to their word
They seem like family to me
They don’t view us as a diagnosis – they respect us as individuals
They’re very polite, supportive, and nice – never give us a hard time
They give us a lot of honest feedback
They’re nonjudgmental and patient

Note. The statements presented in the table represent composite statements created from the participants’ words, after all redundancies had been eliminated.

Theme of Rewarding In-house Duties

The theme of Rewarding In-house Duties was another strong theme (see Table 6). Members provided many examples of the different tasks that they participated in. This included basic tasks such as cooking, cleaning, and taking attendance; to more complicated tasks, such as peer training, planning recruitment drives, and running activity groups. One member explained:

People can have mental illness and go to work. I’ve seen that happen in here.

There’s some great people who have gone and gotten jobs and they’ve all had
mental illness. So it’s not really a death sentence. In here they give you the tools to cope with working.

Members repeatedly reported that they are not required to do any of the in-house duties, but instead volunteered their services to the clubhouse and other members. One participant reported:

We’ve had people who’ve come here from long stays in the hospital or other places where things are all scheduled. And that’s what they’ll ask, “What time do we have to do this?” Or, “How long do we have for this or that?” And we say, “You don’t.” So, I think that’s very good, but I also think that you have to learn that you can be more, make your decisions by yourself with help. Somebody might ask something, and somebody else might say, “Well, what do you think?” Or, “Try it. Give it a try. See what happens.” You’re just not told what to do. You’re encouraged to try.

Some members reported learning new skills while others reported that they can help others by utilizing the skills that they already possess. One member explained:

I was a teacher. And I still feel that I am a teacher. I always did do things for other people. And, that always made me feel really good. That’s the time when I’m at my best – when I’m helping other people. And I am, I’m tutoring someone, two people here. And I love that.

Others reported that the basic structure of the work-ordered day is important to them. One member stated “It helps you, helps you get back into like what they call the daily grind… There needs to be some sort of sense of structure. You know, if you come
consistently the structure helps.” Others noted the variety of tasks that they can “try-out.”

A member explained:

It varies from day to day. You don’t always do the same thing every day. Like, Tuesday I don’t normally work in the kitchen, but somebody needed help so I automatically jumped in. And that’s what I like to do – jump in when people need my help.

Another member reported being pleasantly surprised by how he could help others. He explained:

I just helped another member who never had an email account. I helped him set one up. And, I don’t know that much about computers, but I know how to do that.

So, I mean, even the little victories like that are something.

Furthermore, the notion that the in-house tasks could lead to future employment opportunities outside of the clubhouse is not lost on the members. One member explained that:

I’ve learned a lot. I really enjoy coming here, because I meet a lot of different people and I’m learning a lot of different skills. And, sometime I might get a volunteer job, something like I’m learning here… I’m actually getting out and learning different kinds of job skills, you know, if I ever did want to work. I’d have of a lot of these things learned. You know, like be able to get a job wherever I could, you know, without being discriminated [against] because I don’t know how to do this or that. Been a good experience.

Table 6

Positive Statements Regarding In-house Duties
Coming here, doing work is fun for me

The work-ordered day provides important structure for me

You can always come back here – you’re always welcome, always a member

The tasks we do can differ from day-to-day – it keeps it interesting

If something needs to be done, I’m willing to jump in and do it

You’re not forced to anything here, nothing is shoved down your throat

If I’m uncertain about a task, someone will encourage me to give it a try or help me out

I love that I can help or teach the other members new things

Together we can do all of the duties needed to run this place

Here, I can work at my own pace

The work here is similar to the tasks at home, in everyday life, or at work

The work is like therapy

Some of the work is really difficult – and really rewarding

If you’re having a bad day or not feeling well, someone will cover for you

Everyone works cooperatively – everyone’s on equal footing – we’re a team

I can take these skills into the real workplace – and that’s ideal

The tasks are broken down into simple steps so they can be completed easily

I continue to get more involved in the duties – especially helping others

It’s a good experience

It’s learning by example – from the members and from the staff. It’s like a mentorship

Note. The statements presented in the table represent composite statements created from the participants’ words, after all redundancies had been eliminated.
Theme of Positive Transitional Employment Placements

Nearly all of the statements describing TEPs were positive. There were, however, substantially fewer statements about TEPs than statements about in-house work (see Table 6). This can be attributed to the fact that there are substantially fewer TEP positions than in-house duties. There were also many fewer TEP statements from the members at the rural clubhouse than the members from the urban clubhouse. This, again, is due to the number of different TEP opportunities at each location.

One member reported that he thought TEPs were helpful in reducing the stigma often associated with mental illness. He stated:

The clubhouse is battling this one-on-one. And a lot of that is done through the transitional employment placements that they have – where the employer knows that you’re a mental health consumer. You know, you’re not going to be discriminated against… And, it gives people a chance to deal with [mental health] consumers… and [then] realizing that we’re not so different.

Another member noted that TEPs help members participate in the world of work and reap the rewards that some people with disabilities often do not enjoy. He stated that it gives members the opportunity to:

… actually earn some extra money, which can be real helpful if you want to do things. Because, disability [insurance payments], let’s face it, only goes so far. You don’t get that much. And by the time you pay rent and your other expenses there’s not a whole lot left over at the end of the month. So, if you’re not working somewhere, it’ll be very hard to make ends meet. [TEPs are] only one element in
an effective recovery plan. And it’s a big part. Because it’s going to meet needs that aren’t being met elsewhere in the system.

Table 7

Statements Regarding Transitional Employment Placements

There are a lot of benefits to employment – including the extra money
It’s a good deal for employers – they’re guaranteed coverage
Employers get employees that cherish the job
TEPs help reduce the stigma against people with mental illness
TEPs are big part of the recovery process – they meet needs that aren’t met elsewhere in the system
They are very positive experiences
There are a lot of fun TEPs available [at the urban clubhouse]

Note. The statements presented in the table represent composite statements created from the participants’ words, after all redundancies had been eliminated.

Theme of Other Positive Services

Clubhouses were established so that individuals with serious mental illness could support each other towards their goals. This mutual support continues today, with vocational rehabilitation identified as one of the primary services. Many other secondary services, however, are also provided. As an example, clubhouses are places where individuals do not have to focus on their illness. Many of the interviewees, however, reported that they do receive some form of mental health counseling at clubhouse. One person explained, “It’s not entirely a work environment. There’s still room for counseling – on an as needed basis.”
There were several different types of other services that interviewees spoke of, but because they were not repeatedly cited, they were folded into this Other Services category (see Table 8). These included activities and services like socialization, education, nutrition, and networking. These topics are important aspects of the clubhouse and merit inclusion despite their lack of repetition in interviewees’ statements. They were, however, simply not as evident as one cogent, distinct service. Additionally, housing was included in this section because only one of clubhouses included in this study offered housing to its members, and only two of the 14 interviewees had any experiences with this type of housing service.

The participants were highly appreciative of the fluidity of services provided at clubhouse. One member described a difficult experience in which clubhouse staff and members provided services beyond those ordinarily expected. She described how difficult it was to cope with her mother’s death and how staff and members were able to help her process her loss. She explained:

They were very helpful. They even sent flowers and they sent a card. And people sent all their sympathy on the card. And that just made me feel better. And I think I might of even came here the day of my mom’s funeral…They even, like, once in a while try to get me to talk about it. And I talk about it to them. I feel comfortable talking about it to them. Like, stuff we used to do and like the joking things that me and mom always said and stuff. So, they just made more comfortable to talk about it.

In explaining the nature of services offered at clubhouse, one member emphasized that it is clear that it is a strengths-based program that assists with vocational
rehabilitation, but stated that it provides other support services for many different aspects in peoples’ lives. He explained:

This is not [traditional talk] therapy, and therapy isn’t here. You’re not here to talk about your problems and have them solved and all that stuff. So, in a way, they serve to eliminate a lot of that sort of weird interaction. It not only takes the pressure off, it keeps it more safe – more functional. This is more of a supplement [to other community services]. I mean, you can have as many programs as you want in [the town’s name omitted]… you can have [the hospitalization program’s name omitted]…, your own group home, [and such]. You know, this can be supplemented with any of what you’re doing.

Table 8

Statements Regarding the Other Services of clubhouse

They help me with my finances and in reading forms and letters that I don’t understand
They provide good, balanced meals
You can participate in soothing conversations
They provide fun social events
They taught me to understand that recovery is possible
I can clear my head here and don’t have to spend $50 on a psychiatrist
The social activities they provide are like therapy for me
They provide education, like how to take your medications
They monitor your mental health and offer counseling when needed
They’re out there fighting mental health stigma and promoting the idea of recovery
The housing is great. I don’t think I’d be able to live in the city without them

Note. The statements presented in the table represent composite statements created from the participants’ words, after all redundancies had been eliminated.

Theme of Positive Behavioral Changes

Many of the statements made by the participants described changes in their behaviors as a result of attending clubhouse. This included improved work skills, but also included improvements in activities of daily living and interpersonal skills. These behavioral improvements were in a variety of different aspects in the participants’ lives.

One person explained the behavioral effects of attending clubhouse as:

… just being around other people has really helped me. Before I started the clubhouse, I could not do very much – I was very isolated. And coming in the clubhouse, built-up social skills, which I’m still working on. But it has helped me to relate to others, in helping them and myself. I would not speak very much. To do an interview, such as this – or even when I would go out socially. And, I’ve brought myself to where I can talk in front of people now. And before it was even hard to make an appointment on the phone. The clubhouse has brought me a long ways with that.

Another member reported how an improved sense of self has helped her become more active in the community. She explained that she has stopped being withdrawn and overly critical of herself and has instead started letter-writing campaigns and speaking out publicly. She stated:

I try to do my best [in public speaking] and the important thing is getting the word out there [about stigma] and sharing about what needs to be known about mental illness – reducing stigma and what would help individuals in recovery with
mental illness. That’s something deep within me that I feel needs to be done… I may have felt like I didn’t have any skill or anything like that. But getting involved and being able to say, “I can do this, I do have this strength, I am capable.” And it makes you think, “I can do for others.”

Still, another member declared that clubhouse “is most probably one of the biggest reasons I haven’t picked up alcohol in 20 years.” He explained that the peer support and the fear that a relapse to alcohol use would cause him to lose everything he has worked to establish, including his clubhouse sponsored housing. The majority of the reports, however, focused on changes in how members related to others. Specifically, several of the interviewees reported that they no longer isolated within their homes for days on end. One member who reported being prone to isolating, explained, “I try to come in to [clubhouse] instead of staying home…. I’ll go home after a full day… and feel a lot better about myself.”

Table 9

Statements Describing the Positive Changes in Behaviors

I clean my home more often now
I’m able to have “normal” conversation with people – I’m not so focused on myself any more
I’ve really improved my social skills – I’m much better at talking and making friends
I attend more social functions
I’ve become more active in advocacy and political issues
I take on more leadership activities
I’m much better at sharing now – I like to do for others
I don’t sleep all day or isolate in my apartment anymore
I’m willing to try new things and do more work in general
I stand up for myself and speak up more often
I don’t fight with family as much
I do more studying on topics that I enjoy

*Note.* The statements presented in the table represent composite statements created from the participants’ words, after all redundancies had been eliminated.

*Theme of Positive Changes in Thoughts and Feelings*

Positive changes in thoughts and feelings was one of the strongest themes in the participants’ statements. Their explanations of how membership has changed the way that they think and feel about themselves and the people and world around them defined this theme. All of the participants reported, in one way or another, that clubhouse makes them “feel good.” This sentiment was by far the most repeated idea from the interviews. Asked to further explain what it is about clubhouse that makes them “feel good,” many explained that being a member has increased their self-esteem, confidence, and sense of self-worth. One member attributed her increased confidence to being asked to do simple tasks that no one has previously asked her to do. She explained, “They just have faith in me – even though sometimes I don’t have faith in myself. And I get self-confidence that I can do things that I didn’t think I could do… I just feel overall real good about myself, coming here.”

Another member attributed her changes to the overall supportive atmosphere within clubhouse. She stated:
I became more confident in working with other members and sometimes I felt…

that there were some things that I could not achieve – maybe it was beyond me.

But I had encouragement from members and staff and, you know, “Try it.” And,

“It’s okay to make a mistake.” And that’s a big thing – not having the pressure on

you. That, if I make a mistake, I’m not going to be told that I can’t make a

mistake – because mistakes are a part of learning. That has really helped me to

gain my confidence.

Another participant compared the supportive atmosphere to other, more widely

known, programs that are also built upon mutual support. He explained that mutual

support has multiple benefits. He stated:

I mean, programs like Al-Anon and AA work because you share your experience,

strength, and hope. And that’s how we help one another in these programs.

Clubhouse is the same way. You help others, but in the same way, as your helping

others, you’re helping yourself too. Because, again, everyone needs to feel some

kind of sense of value…. I think it always contributes to your well-being, to your

self-esteem, whenever you’re able to help someone else.

Still others explained that the clubhouse has changed the way they view

themselves and their problems. One member stated that it has moved him from self-pity

to more rewarding activities. He noted, “By helping them, it gets my mind off myself.

You know, instead of, ‘Whoa is me.’ You know, I’m up and trying to reach others. Yeah,

it makes me feel a lot better.” Another participant echoed that idea, but further explained

that clubhouse has helped her after years of being mistreated by others. She stated that

clubhouse “… makes me feel better because growing up I was always put down and
rejected. Because [others] looked at me like, ‘She’s stupid,’ or you know, ‘She’s retarded.’ But coming here, I don’t have to feel that way.” Membership in clubhouse, she explained, has given her a heightened sense of self-worth, so much so that she feels her overall personality has changed for the better.

Many of the participants stressed that clubhouse has also helped them to feel connected to others and a larger community – especially after many years of feeling stigmatized as “outsiders.” One participant reported:

There’s probably a couple a people here that actually have [the same diagnosis]. And this place will help you feel comfortable knowing that there are other people out there who kind of share the same thing you [have]. And that mental illness is not exactly a bad thing – it’s not easy – it’s not hard. It’s nice to know that I’m not the only person here that has [an illness].

Another interviewee reported, “I just feel like I found a place in this world where I fit. I never felt so good, being here – in a place like this. It’s more uplifting and just makes me feel really good.”

She went on to emphasize that the sense of community goes beyond the feelings of belongingness. She explained that she struggled to attend high school because of the constant teasing from other students, but at clubhouse she “actually feel[s] needed.” She explained, “I think it’s funny, because I’ve never had anybody expect me to be there for them. The truth is, I feel much better about myself here… It’s a big booster – a boost in the self-esteem department.”

Several of the members reported internalizing concepts often associated with recovery. One participant explained how the TEP program has helped him to feel more
independent and in control of his life. He stated, “The paid labor – it gives you a sense of empowerment. Because in our society empowerment means purchasing power – so a little bit of cash is good.”

Interestingly, two participants explained that the recovery process is subtle, but important. One interviewee emphasized, “It’s not dramatic, but it makes a day spent here [at clubhouse] worthwhile.” Speaking about empowerment, another participant explained:

I’ve actually run some of the house meetings that they have there. I’ve actually facilitated. So instead of having someone picking things out, telling you this and that. Even if it’s in a small way, it’s still something. I mean, even in the kitchen unit, the kitchen unit gets to make the decisions as far as what the menu is going to be for that week, you know, you’re planning the meal, you’re providing it, and no one’s going to stand over your shoulder and tell you what you need to do. And, on a small level, that’s an empowerment thing.

He went on to explain how practicing different skills at the clubhouse helps the members to feel empowered to repeat these activities within their private lives.

Other members described how being a part of the community has not only helped them understand themselves, but it has helped them to change the way they think about other people. One participant reported:

I think it helps me understand other people better – realizing that, okay, I have a bad day, [so] they’re allowed to. And I put aside my petty little concerns… because I want to help them with whatever they’re going through…. So I think it helps me to have more empathy for people.
The participant who previously reported that she was teased throughout high school explained how that teasing negatively affected her and how clubhouse has helped to alter her thinking. She stated:

I always viewed other people – outside of my family – as people who won’t understand me or people who won’t get along with me. Or, just in general, like, *mean*. When I came here, I found a lot of people were really nice…. So I view people differently. Like, I’ll be more open to new people…. It’s pretty cool.

Unanimously, the participants reported that they feel they have benefited from the clubhouse. Along with the more detailed explanations of the benefits of clubhouse, the interviews were also peppered with simple declaration of satisfaction. One member stated, “I mean, all I can say about it is it’s very uplifting.” Another member explained, “I feel better when I’m here. I feel happy when I’m here.” And, despite not being a program focused on illness, one member summarized his clubhouse experience as, “The illness will be there. It’s actually my destiny… but it [clubhouse] can really help the illness.”

Table 10

*Statements Regarding Changes in Thoughts and Feelings*

- This place makes me feel good – it’s very uplifting
- Being here helps me to gain some perspective on my problems – they don’t seem so large
- I feel reassured about my abilities – I feel capable
- Clubhouse is empowering
- I feel very fulfilled and rewarded
- I feel better – I’m just happy when I’m here
- It’s changed how I view others
Coming here makes me have more empathy for others

I have a better understanding of others and myself

I have a better understanding of the ups and downs of mental illness

It makes me want to be more social – more active, and get a job

This place builds my self-esteem and gives me more confidence to try new things

I feel needed – valued as a person – accepted

I’m more motivated and productive – It gives me a sense of accomplishment

I feel like I’m connected – a part of something and contributing to society

It gives me a more positive attitude – I’m more willing to learn

I now understand that I have a lot of potential

I feel much better about myself – I now think of myself as an adult

Note. The statements presented in the table represent composite statements created from the participants’ words, after all redundancies had been eliminated.

A Composite Description of the Clubhouse Experience

In creating a composite description the clubhouse experience, I assembled all of the previously noted themes and significant statements and interpreted them into one passage. In doing this, I considered all of the themes and representative statement lists. This, however, left me with several themes and statements that directly contradicted one another. As an example, the clubhouse staff were described as being insensitive in one instance, but caring and supportive in nearly all the other statements. In consideration of these contradictions, I employed the practice of imaginative variation (Moustakas, 1994) and systematically considered the possible underlying contexts and structures associated with the contradictory statements in an effort understand the broader meaning of the statements.
Identifying the context and themes was greatly aided by the participants who were explicit about the underlying structures of their negative experiences. Several of the interviewees framed their negative experiences in their observations “that there’s always going to be a few bad apples” (regarding poor quality staff), or that within any groups some conflicts will arise (regarding other members). Additionally, in more self-reflective comments one member highlighted the difficulties of discerning reality from distortions in thoughts (i.e., paranoia) created by his mental illness, while another participant noted that her years of mistreatment have caused her to be somewhat distrustful and suspicious of others.

In sum, my final construction of the composite statement regarding the clubhouse experience includes the negative experiences in consideration of the substantive weight of the positive experiences. What follows is the final composite description of the clubhouse experience.

*The Clubhouse Experience from the Members’ Perspectives*

Participants described clubhouses as community centers established to help individuals with serious mental illness. These community centers are specifically planned and designed to be warm, attractive, and inviting spaces that offer access to everyone. The interviewees explained that individuals who join the clubhouse are referred to as “members” and the staff are typically referred to as “generalists.” One participant explained how the physical arrangement of the building resembles a typical job site, yet it creates a positive atmosphere where generalists and members can support each other. He noted:
Physically the place looks like you’re going to a job and not a therapeutic situation – with the space being divided between the kitchen and the office area. That’s the first impression. [Long pause] If people need emotional support, we give it to each other. And, we’ve introduced some goals to be reached – and in my case, it’s uh, being more [long pause] improve my computer skills.

Interviewees also explained that the centers offer support and help in a variety of ways. A key feature is their unique version of vocational rehabilitation. This model emphasizes skill building through peer support. The centers are specifically structured to not focus on individuals’ mental illness, but instead have a purposeful focus on individuals’ strengths. Interviewees explained that they are encouraged to engage in work activities, including two important avenues of vocational rehabilitation: in-house volunteer work and Transitional Employment Placement (TEP) outside of the clubhouse. In expressing his appreciation of the strength-focused structure, one interviewee stated:

So, my days weren’t spent talking with, or about, other people’s [problems] – with my problems or other peoples’ problems…. That’s one of the things I had to become used to is not having a job and just focusing on getting better. And so this place offered a sense of normalcy.

Interviewees explained that a minimal number of generalists oversee the centers, and as such, the in-house volunteer work is vital in maintaining and operating the centers. They explained that the in-house volunteer work is an important step in establishing work histories and in building the skills that may help them transition into “real world” job placements. Members are encouraged to try the different in-house duties that are needed to operate a community center. This, according to the interviewees, may include assisting
in meal planning, cooking, cleaning, clerical, recruitment, peer-training, peer-advising, peer-education, budgeting, and advocacy activities. When appropriate, members are encouraged transition into TEP position in companies throughout the community. The TEPs, according to the interviewees, are typically cleaning, retail, or clerical jobs that last from 6-9 months. An interviewee described his experiences with TEPs as beneficial. He said:

I’ve had two TEP positions. One at [the site’s name omitted] and one at [the site’s name omitted] as a file clerk. So both jobs were very positive experiences. And I couldn’t have gotten them without the transitional employment positions. They gave me training and the opportunity to work…. The first job was a service position to help people who were using the [swimming] pool. So I got to be upfront and to work with people and make their stay at the pool a pleasant one – by giving them towels and their locker keys and doing a little bit of laundry on the side. So, it um, it had me [pause] it gave me more contact…. The working and the people that I worked with were conversationalists. So, working with optimistic students was very [pause] their enthusiasm rubbed off on me.

Additionally, clubhouses offer social activities and some locations offer comfortable and affordable housing. The interviewees’ expressed gratitude for the services that helped them beyond vocational rehabilitation. One participant stated:

It’s almost like there’s two entities to it. You get, like I said the [physical] building part of it. But then there’s this other part of it. The social aspect of it, which people love more than anything. We have a pizza night here – it’s a blast. But that give me a chance to talk to people that are in the same boat that I am…. 
There’s a lot of [non-clubhouse] people that I talk to, but they don’t understand mental illness. They just don’t. It goes across their head. But, in here people go, “Oh, I’ve dealt with that.” Or, “Oh, I had to deal with that – you do this.”

Members reported benefiting from the clubhouse in a variety of ways. At its most basic level, clubhouse provides them with a place to go and some structured activities. They have the opportunity to learn new skills that help them in both work and home lives. More importantly, interviewees stressed that clubhouse provides them with an atmosphere where they feel welcomed, safe, and free of the stigma that the public often associates with mental illness. One interviewee explained:

I work along side some fine people. I mean, I couldn’t of asked for a better environment than this clubhouse. I just wish I would have had it when I was little. I probably would have come out better, a lot better than I am right now…. I feel better when I’m here. I feel happy when I’m here. I actually cry when it’s time to go home.

According to a few interviewees, some interpersonal difficulties may arise between members or between generalists and members, but these difficulties are typically remedied through the support and guidance found within the clubhouse.

Interviewees described the generalists as well-trained and educated. Additionally, they are seen as being genuinely invested in their work and in the well-being of the members. The interviewees explained that the generalists are overwhelmingly positive mentors who are supportive, respectful, true to the word, and lead by example.

For its members, the clubhouse experience includes having a family-like sense of belonging within a friendly community that cares about and nurtures its members. The
interviewees reported feeling needed within a community where strong friendships can be built. One interviewee explained that other types of community services have value, but clubhouse’s mutual support system provides additional benefits. He explained:

It’s more – you know that what you’re doing is important. So there’s a certain therapeutic value in knowing that, um, that you’re needed. That, you know, they [other members] value your skills and abilities and they’re willing to teach you what you don’t know.

Interviewees emphasized that providing mutual support for one another allows them to interact in meaningful ways that help them in building confidence, self-esteem, and a sense of empowerment. Having the shared experience of living with mental illness, according to the interviewees, allows them a greater sense of empathy and understanding for one another. They stressed that the positive energy and continual encouragement helps them define and move toward their individualized goals of recovery.

Clubhouses, according to its members, are places where individuals who have traditionally been discriminated against and mistreated can instead be treated with respect and dignity. They are places that individuals can feel good about themselves and help others to do similarly. Despite its non-illness focus, interviewees explained that clubhouses assist them in maintaining mental health stability, while helping them to feel like happy, competent, capable, and contributing members of society. One member summarized her clubhouse experience and the therapeutic value of it as:

It’s a wonderful community to get involved in. You learn, you learn the best about yourself, you learn the best about others. There’s a lot of, um, we’re cheerleaders for each other. A lot of people have stepped out to places they never thought they’d go. And it’s,
it’s just a family community. Everybody in their own ways reaching towards some kind of recovery, or resolve, or even if you need to take some steps back, you know that people are here to help you come forward, when you’re ready.
Chapter 5

DISCUSSION

Summary

The purpose of this study was to gain a better understand of mental health clubhouses and how members view them. Clubhouses are community mental health centers that have jettisoned the traditional medical model of treatment, which is built upon a healer/patient dynamic. This healer/patient relationship relies on the so-called expert to diagnose and then cure any illness. The clubhouse model instead relies on a mutual support model where each individual is seen as his or her own expert and encouraged to interact with other community members in meaningful ways. This model runs counter to the medical model’s goals of total symptom abatement.

The clubhouse model was developed in New York City nearly 60 years ago, but its spread to other communities has been relatively slow. Within the last decade, however, clubhouses have become an increasingly popular means of providing comparatively cost efficient services to individuals with serious mental illness (Cowell et al., 2003; McKay, Yates, et al. 2005). Despite this recent growth, very few researchers have studied the model. This research project was designed as a step toward redressing the scarcity of research and providing a better understanding of clubhouses.

This study followed a phenomenological qualitative research design. The basis for utilizing this approach was two-fold. Firstly, phenomenology is the most appropriate strategy to answer my overarching research question: What is the clubhouse experience? Toward this, phenomenological research strategies attempt to capture the invariant subjective experience of a particular phenomenon. For this study, a phenomenological
design was used to capture the essence of the clubhouse experience. Secondly, clubhouses have a philosophical precept that stresses the maximum amount of member involvement in all activities. This maxim explicitly asserts that members need to take a greater role in the daily operations of the clubhouse and within research efforts. As such, a phenomenological design allowed me to build my research upon the first-hand accounts of the members and to include them in the research at three different junctures.

To wit, I constructed a series of 12 open-ended questions and individually interviewed 14 clubhouse members. The questions were designed to elicit their perspectives on the clubhouse experience. The interviews lasted between 45-60 minutes, were tape recorded, then transcribed. I completed the transcriptions myself. Each interviewee was asked to review his or her respective transcript for accuracy and invited to make whatever changes were needed. I read and re-read the transcripts, in an effort to identify significant statements and common themes about the clubhouse experience. When themes were identified, the significant statements were coded and sorted into the appropriate themes. Redundancies in significant statements were eliminated and representative lists of statements were created. Accordingly, on-going consultations with a peer reviewer helped in the development and verification of themes. A composite description of the clubhouse experience was created from the significant statements and themes. This process culminated with a review of the composite description by four of the interviewees. All of reviewers reported that it was an accurate reflection of their experiences.

Notably, this study’s finding are strikingly similar to the epoche (or bracketed ideas) that I constructed prior to conducting the interviews. The bracketing of any
preconceived ideas regarding the issue being studied is an import part of establishing rigor and trustworthiness. It is, according to Creswell (1998), an important process that allows researchers opportunities to reflect on whether preconceived notions are influencing the findings. As findings emerged, it was apparent that they closely resembled my epoche. Because of this, I was careful to continually consider whether my findings were being affected by my own expectations. While analyzing the data, I repeatedly reflected upon whether my conclusions were truly created from the subjective reports of the members. Throughout the process, I felt comfortable that I was accurately reporting what members had offered.

Additionally, in peer consultation I repeatedly questioned whether my conclusions were borne of the data. My peer consultant consistently confirmed that my themes and conclusions were based upon the words presented by the participants. Moreover, when I presented the transcripts and composite description to the participants, no objections were raised. These participants reported that they viewed the statement as an accurate depiction of the clubhouse experience for them. They offered several complimentary phrases, such as, “Nicely done,” and “It’s very good.”

The composite description highlighted the overall positive impact that the clubhouse has had on its members’ lives. No previous research has addressed the impact of clubhouse on its members’ lives. Specifically, the members reported that other members, as well as staff have had a positive impact on their moods, self-concept, thoughts, and behaviors. One member described the clubhouses affect as:

It makes me feel good. When I first – before I even head of the clubhouse, I needed a reason to get up out of bed in the morning. I was that down in the
dumps. But knowing that I got a place to go and where people need me it’s like, “Ah, I better get out of bed, I better get going these people count on me.” I mean even though we don’t get paid, the reward is seeing smiles on people’s faces and you helped them.

Interviewees identified the various in-house duties, TEPs, and the overall support and encouragement as aiding in the process. The final description of the clubhouse experience stresses that the members view the clubhouse as a safe, warm, and welcoming place where their mutual support works toward empowering its members. This empowerment may assist in creating positive changes, such as those found in Pelletier et al.’s (2005) study of an in-house weight management program.

Additionally, the composite description of members’ experiences notes that, through work activities, the members are able to build skills that can help them in their everyday lives and in future work situations. Previous research by Yau et al. (2005) suggests that clubhouses can be effective in improving skills on a specific work-related task, yet no research efforts have been made into whether the skills that members learn can be transferred to other arenas of the members’ lives. In my study, however, several interviewees reported that the support and encouragement they received from staff and one another was greatly appreciated and assisted them in transferring in-house skills to “real-world” applications. One member explained how he values the skills that he has learned and how it has affected his life outside of clubhouse. He explained:

I’m cleaner! [laughs]. I don’t know. One of my goals here is, you know – like you don’t have to, but you can volunteer as much as you want. So I clean. And when I
go home, it helps me out – doing it here, I go home and I’m much cleaner.

Cleaning up my room and all.

Additionally, the findings align with much of what has been previously established in the counseling and psychiatric rehabilitation literature. It has been established that empathy, genuineness, positive regard, and acceptance are powerful tools for affecting positive changes (Rogers, 1951). Given such an environment, Rogers explains, individuals will feel safe enough to fully explore themselves and make changes that will lead to fuller, more satisfying lives. These basic human services tenets are critical in encouraging self-exploration and self-actualization. As a counselor and educator, I have come to greatly value Rogers’ teachings and I work toward keeping his recommendations central in my professional and personal life. My appreciation of Rogers’ work stems from years of training and first-hand enactment of his treatment strategies.

Uniformly, all of the interviewees described experiencing caring, supportive, and encouraging interactions within the clubhouse. Many of the caring and supportive interactions were member-to-member interactions. These interactions, according to the interviewees, have helped in building their confidence and self-esteem while moving them closer to their goals. Interestingly, the participants were not trained in counseling, yet many of them described receiving the critical components of Rogers’ (1957) so-called necessary and sufficient conditions for therapeutic change (i.e., empathy, genuineness, positive regard, and acceptance) from other members.

Some of the interviewees explained that living with a mental illness and being within the clubhouse environment allowed them to more accurately understand the
experiences of their peers. One member emphasized that having a mental illness affords him a deeper empathy and genuineness that can only be gained through first-hand experiences. He explained, “You can read all the psychology textbooks you want, but if you haven’t actually been through it, you can’t begin to understand what it’s like.” Another member explained how her experiences have helped her to become more compassionate about those around her. She explained:

If someone’s having a bad day I want to help. And I put aside my petty little concerns for their well-being. Because I want to help whatever they’re, help them with whatever they’re going through. Because it’s not – it’s not an easy thing for anybody – being mentally ill, it’s not one big party. So I think it [having a mental illness] helps me have more empathy for people.

Lastly, the psychiatric rehabilitation model emphasizes encouragement and the instillation of hope in the development of individualized, strength-based, and recovery-oriented goals (Pratt, Gill, Barrett, & Roberts, 2002). Many of the participants detailed exactly that. There was an overall consensus that clubhouse was helping them to adjust to their mental illness and live more fulfilling lives. One member explain that he was not currently feeling as if he was ready for employment, yet he continued to attend clubhouse and work on simple tasks. He explained how staff has been helping him to participate:

Tasks are easily chopped into blocks. So if you feel comfortable doing one task, you can do it. You can feel proud. You can say, “Hey I did something today”….

And here, if I do at least one or two things, I can write on my goal sheet, that hey, I worked toward my goal of, you know, being more functional and working. Even though I’m not seeking work, at the moment.
Findings

From the analysis of the interviews, it is evident that the participants value clubhouse’s services. Some members did report having negative experiences within the clubhouse, but these accounts seemed to be isolated instances that were vastly overshadowed by the positive experiences. The overall descriptions of their experiences painted an overwhelmingly positive portrait of clubhouses. Entering into this research, I anticipated that the interviewees would report being satisfied with clubhouse’s services. From my previous work and professional contact with clubhouse members, I understood that many clubhouse members were satisfied with the program. What was revealed in these interviews, however, did surprise me. Most striking was the high degree to which members were pleased with the program and how truly thankful they were for it. Moreover, the intensity of personal growth and positive changes attributed to being a member was rather astonishing and unexpected.

Significantly, all of the members were able to cite several different ways in which they benefited from attending. Some of the interviewees initially had difficulties in expressing what the clubhouse experience was for them, but throughout the course of the interviews, they were able to provide examples of how they benefited from the program. One interviewee explained, “Actually, since I started coming here, I’m more perky and more positive. And, I just feel like, I’m actually out there – in a positive atmosphere – where, you know, mental health people are accepted.” None of the interviewees reported being adversely affected by membership.

Importantly, the individuals described a unique style of treatment and interventions that are not provided elsewhere. Many of the interviewees explicitly
stressed that they do not view clubhouse as a redundancy of the other services available in the community. Participants described it as an important “supplement” to other services and filling a distinct “niche” not being served by other programs. This seems, in a large part, due to the sense of inclusion in running the programs and the freedom to participate at whatever level members are comfortable with. Many of the interviewees noted that their freedom of choice added to their enthusiasm about the program. One interviewee enthused:

It’s you – you’re not obligated to stay if you don’t want. It’s totally your choice what you do. The people here are friendly. Like [staff names omitted], and this place is cool to network, to make friends it’s just awesome! They don’t, they don’t put pressure to come if you don’t want to. That’s what I like about this place.

The freedom of choice can sometimes be taken for granted, but for individuals with serious mental illness, their freedom to choose treatments is often impinged upon by courts, mental health workers, and program requirements.

Additionally, the somewhat unconventional style of interpersonal interactions within clubhouse seemed to aid in creating a favorable environment. Several of the interviewees reported that they benefited from “the hugs and kisses” that were exchanged at clubhouse. Such behaviors are not typically encouraged or even tolerated within some mental health programs. When I asked one participant to describe how she interacts with other members, she explained, “Well, I give them hugs and kisses. And, um, I like to kid around – joking, make people laugh.” This more “up-beat” and “relaxed” atmosphere
helps individuals who often isolate to return to the clubhouse. She went on to explain that:

I can let my hair – even though my hair is short, I can let my down here. I can be myself. I can kid the staff. And make them laugh and all. I’ll compliment them, and make them laugh…. I do well in social situations better. And for my loneliness – it cripples me almost every day – and I come here for that reason too, to be around people and get out of my apartment.

The interviewees also noted that, through participation in clubhouse activities, they improved their work and interpersonal skills, felt connected to a larger community, gained insight into their illnesses, were motivated to make positive changes in their lives, and obtained an overall improvement in self-esteem, confidence, and mental health stability. An interviewee explained the interconnectedness of skill-building and an overall improved sense of self. She noted:

I’m actually getting better in this place. My typing was terrible. I mean, it wasn’t terrible, it was boggled up. Now it’s getting really much better. I’m getting more accurate and more speed. And I’m feeling better. Mentally I feel better…. I just know I feel better here. I think it’s a combination. It’s a combination of me and the clubhouse. It, it has to be a relationship.

Importantly, many of the individuals reported that the clubhouse environment was one that made them feel valued and needed. This is significant in that individuals with serious mental illness experience high levels of stigmatization, which can contribute to isolative behaviors, non-compliance with treatment recommendations, and overall poor quality of life (Pratt et al., 2002).
Based on the interviewees’ experiences, the clubhouse model is effectively fulfilling the guiding principles of the psychiatric rehabilitation movement, while also meeting the mission goals put forth by the ICCD (2002b). The psychiatric rehabilitation model recommends that individuals partake in client-directed, individualized services that emphasize partnerships with professionals who offer hope and on-going support and encouragement (Pratt et al., 2002). The participants invariably reported that they had the freedom to choose their own level of involvement in clubhouse activities and that staff and other members were willing to work side-by-side with them. One member described this as:

It means taking on some responsibilities. Also, acting in a way that encourages other people to do the best that they can here. If they [other members] see me busy here, and if they see me doing my best at a job and then coming to clubhouse, uh [long pause]. A lot of what I got was learning by example. So in a way, the people that run clubhouse are mentors – even though they don’t know that. It’s not expressed in that way, they actually are.

Additionally, the participants reported feeling as if others cared about their well-being and that their membership has offered them a sense of hope for an improved future. A participant explained:

It makes me feel good to help others. It has given me confidence and it really makes me feel like my life is worth living. It’s not always, it’s not always the money, you know. I’m not into, like, I like doing my volunteer work. I’m giving, and I get back from what I give – in the heart…. But it really feels good helping somebody else out, and see them reach up to their next level, like – a lift up. And
to see them feeling really down, to really, you know, starting to do what they need to do…. It just, they may be sinking down and you go and you help them and it just gives them a little bit of that push in life to really make them want to get some hope. And I know that when I was really struggling, I appreciated that help from the clubhouse – to give me that hope.

Much of the information gathered aligns with the standards set by the ICCD (2002a). At its core, the ICCD standards “insist that a Clubhouse is a place that offers respect and opportunity to its members” (para. 2). One interviewee cited respect, above all else, as the most important feature of the clubhouse.

The interviewees repeatedly stressed that they felt welcomed and accepted within the clubhouse. Such descriptions correspond to the key concepts associated with the recovery movement. Moreover, many of the interviewees spoke explicitly about their recovery, underscoring concepts such as an adjustment to their illness (Corrigan & Ralph, 2005) and how recovery is a process, rather than an endpoint (Jacobson, 2004). Others spoke of fulfilling personalized goals, and having a sense of empowerment and hope.

One participant explained how she has seen recovery within the clubhouse:

Recovery is – [pause] okay – acknowledging that you’ve got an illness, your mental illness, but you’re finding ways to deal with it – you’re coming out of it. And they stress that a lot around here [at the clubhouse]. And that’s what I like. I like the fact that you don’t, you don’t – just because you’ve got a mental illness that doesn’t mean you have to stay in that position, stay in that state. You can come out of it. And, I’ve seen it happen. Um, I don’t know how many times. But when I was little, I didn’t hear any of that. Um, I was pumped full of pills. I can’t
even count the number of pill bottles I’ve collected. And I just don’t think pills are the answer, At least for me. Encouragement. What works for me is encouragement.

Nearly all of the individuals interviewed reported feeling better about themselves due to their participation in clubhouse. Other individuals who explicitly mentioned recovery explained that clubhouse was aiding in the process. One member explained that recovery is a challenge, but the structure of clubhouse helps her. She stated:

I feel like I’m heading toward recovery, but recovery’s a big word. And I feel like I might be always heading toward recovery. But, it takes my mind off of my troubles, and I think for other members this is true. You take your mind off your troubles, and you’re thinking about others, and you’re thinking about the work you’re doing, getting involved – and that makes you feel good.

Additionally, these findings are congruent with the results from Herman et al.’s (2005) concept mapping research. Through a multi-step process of brainstorming, rating, and sorting of descriptors created by clubhouse staff and members, Herman et al. created a visual map of the integral concepts found within clubhouse. These concepts were prioritized as: (a) recovery, (b) social connection, (c) membership, and (d) tasks and roles. These themes were clearly present in all of the interviews that I conducted, lending additional support to the centrality of these concepts within clubhouse.

Furthermore, the interviews provide partial support of Mowbray et al.’s (2006) investigation into clubhouses’ objective of empowerment. Mowbray et al.’s three-pronged assessment (examining members’ involvement in operational decisions, support in problem solving skill development, and overall number of services provided)
concluded that clubhouse members did not engage in any significant level of participation in the general, day-to-day operations of the centers (e.g., hiring, budget issues, activity planning). Contrary to Mowbray et al.’s findings, several of the interviewees for this research project explained that they did indeed play crucial roles in planning activities. One member stressed that member input is central to planning day-to-day events within the clubhouse. He explained:

The staff are very open to new ideas or trying to implement things. And everyone has a hand in planning events. So, again, you’re starting to take, um, responsibility – and empowerment. It’s a big word at clubhouse. Clubhouse is about empowerment. It’s about, you know, making decisions and taking the reign of things and yourself, for your life… Here, you have a say. If there’s an outing, the clubhouse votes and decides how the outings going to be done. We have house meetings, you know, once a week, where, you know, they discuss future plans and activities that clubhouse wants to do. Um, and we have daily meetings everyday. You know, deciding who’s going to do what.

Interviewees did not, however, report being active in budgeting or hiring activities within clubhouse.

Furthermore, the interviewees clearly support Mowbray et al.’s (2006) findings that clubhouse members do experience empowerment through staff’s active encouragement of members in making individualized treatment plans. One interviewee highlighted that members’ freedom to work at their own pace is vital to clubhouses success. He explained, “There’s no forced engagement. Like… [the local day treatment
He continued to explain how he creates his own daily goal sheets and how learning how to assess himself has helped him. He explained:

Well, everyday we have a thing called a daily log. And if we work towards our goal, we check yes. If you didn’t make your goal, you put no… Just checking in on that for myself. I mean, when you’re at home or when you at your job, are you telling yourself, “Hey, am I doing a good job?” I mean, very few people do self-assessment. And I don’t do self-assessment when I’m not [pause]. When I’m at home. It’s very easy for me to have an internal conversation that has nothing to do with anything else. But when you actually see it on a piece of paper, it makes you realize that, hey, I am capable, and I am doing something worthwhile. And I completed a task. Wow, surprising!

Limitations

A limitation to this study is that the captured experiences are solely of active members. One could posit that the interviewees remain active in the clubhouse because they are satisfied with the program and, as such, would speak favorably about it. Conversely, it could also be suggested that former members may be inactive because of their dissatisfaction with the program and would speak unfavorably about it. At this juncture, it is unclear whether either one of these arguments is more valid than the other. One interviewee, however, noted that “in-active” members do not necessarily leave because of dissatisfaction with services. He emphasized that in-active members are sometimes “retired” from the clubhouse after achieving their goals or finding independent employment.
Moreover, the post-constructivist nature of qualitative research suggests that another researcher could reach conclusions vastly different than those presented herewith. Several steps were included in an effort to bolster the research concepts of rigor and trustworthiness, yet the reliance on interpersonal skills within the data collection process and the subjective interpretations used throughout the data analysis could lead another investigator (or readers) to different conclusions. Moustakas (1994), however, highlights that the aim of phenomenology is not to create absolute truths, but in exploring the interconnectedness of meanings and gaining a broader understanding of personal experiences.

Implications of the Study

*Non-compliance in Treatment*

Importantly, individuals with serious mental illness are commonly found to have a low rate of treatment compliance (Lysaker, Bell, Milstein, Bryson, & Beam-Goulet, 1994). Olfson, Marcus, Wilk, and West (2006) stress that non-compliance for individuals with serious mental illness is “grave and pervasive” (p. 205), often leading to hospitalizations, loss of housing, and other psychosocial difficulties. Some studies indicate that nearly 80% of individuals with schizophrenia fail to comply with medication recommendation (Olfson et al., 2006) while 29% fail to attend routine outpatient appointments (Carrion, Swann, Kellert-Cecil, & Barber, 1993).

Much of the research has linked non-compliance to a lack of insight regarding the illness (Lysaker et al., 1994; Olfson et al., 2006), but client satisfaction is also inextricably linked with treatment compliance (Gray, Elhai, & Frueh, 2007; Ries, Jaffe, Comtois, & Kitchell, 1999).
Within this project, interviewees noted that interacting with others in a safe environment has expanded their understanding of mental illness, medications, and treatment issues. As examples, they provided details of how other members suggested some behavioral changes that lead to improved coping strategies for the side-effects caused by medications and how other members provided relevant information related to recovery. Accordingly, such interactions aided in the members’ increased insight into their illness. Also, the interviewees reported being very satisfied with clubhouse. If clubhouse increases insight and is viewed satisfactorily by members, it could be a useful tool in reducing the high rate of non-compliance for people with serious mental illness.

According to the participants, keeping the members interested in and satisfied with services is an important goal of clubhouse. Interviewees explained that many activities are built around the needs and interests of the members and that they regularly conduct outreach services for the members who may be struggling to stay engaged in the community. An interviewee explained how outreach efforts have kept her connected and motivated to re-engage in the community. She stated:

It was kind of neat, you know. A couple months back though, I was very paranoid. I was isolating. And when they [other members] did call, I was like, “Do you really care?” you know. But, I just got to learn to restrain my [paranoid] thoughts. You know, like, “Okay, they do care.” But, that’s encouraging to have someone call me and say, you know “Hey, we miss ya. How ya doing?” And, “Is there anything we can do?” I don’t get that in the real world. That’s another thing that I like in here. They, they encourage you, you know. They’re gentle with you, but like, they give you a little nudge.
Employment Success

Becker and Drake (1994) assert that the current state of vocational rehabilitation is clearly not meeting the needs of individuals with serious mental illness. This is underscored by the fact that, as a group, individuals with psychiatric disabilities consistently have the highest rate of unemployment of all disability groups (Becker & Drake, 1994). The limited research into the clubhouse model of vocational rehabilitation suggests that the clubhouse is a useful intervention based on vocational success (Drake et al., 1996; Macias, 2001; McKay, Johnsen, et al., 2005) and cost comparisons to other similar programs (Cowell et al., 2003; Lucca, 2000; McKay, Yates, et al. 2005). Given interviewees’ high-level of satisfaction, in light of other research findings, it appears that clubhouse could be useful tool in alleviating the traditionally low rates of employment. One particularly active clubhouse member explained how clubhouse has gotten her back into the workforce after years of unemployment. She explained:

I may have felt like I didn’t have any, you know, skill or anything like that. But getting involved and being able to say, “I can do this, I do have this strength, I am capable.” And it makes you think, “I can do for others.” And, you know, you may be able to build on that, or maybe even go out and get a job. And that just keeps…[long pause] once you work on your strengths, and you keep building on them, and you see the different ways that you can use your talents, for yourself or others. I did not think that I’d be working, you know, like I am now. I did not think that I would be working. I did some labor work, at our last temporary job, and at this one, doing office work. And, I’ve always wanted to work in an office.
That was through building up, through the clubhouse, that gave me that strength
to make me think, “Oh yeah, I think I might try this.”

*For Practitioners and Educators*

Given the interviewees’ overall satisfaction with clubhouse, clubhouse needs to be considered a useful adjunct service in treatment planning. As one interviewee highlighted, “Clubhouse fills a particular niche that isn’t being filled elsewhere in society. I mean, you’ve got a place to come, you’ve got purpose, you’ve got value.” He went on to recommend that clubhouse “should get all of the funding we need to do everything they can do. Because they are definitely meeting a niche that’s not being met elsewhere.”

Another member, when asked why practitioners should know about clubhouse, explained that:

If their clients need somewhere to get away from it all, just to come here. They’ll love it here. They will. Always love it here. They’ll love it. It’s a good place to chill at. If their clients need someplace to feel welcomed, clubhouse is it.

Additionally, members reported that they have internalized many of the core concepts of recovery. One interviewee provided recommendations for all human service workers. He suggested that:

If you’re seeing me [as a client], see me as *me*. As a *person*. Don’t look at my mental illness, don’t look at just the fact that I have a mental illness. You know, because most of the time, in dealing with me, you wouldn’t realize I did if I didn’t tell you. Try and see beyond the exterior.

Several participants reported being disappointed that they and their helpers had little exposure to or understanding of what clubhouse was prior to their joining. These
individuals recommended that greater efforts need to be made to educate practitioners and students. One member, speaking about clubhouses’ “invisibility” stated:

I really don’t think it has to do with the model. I think it has to do with advertising and proposal. I don’t think that people [staff] at clubhouse know – they’re not PR people. They’re usually HDFS majors or psychology majors, or anything else that they decided to [pause]…. I mean, they’re [staff] allocated money and they do their job, this and that. Clubhouse is so non-specific, I think that they have a hard time getting visibility…. It’d be nice if there was one in every town.

This research effort provides evidence that the clubhouse experience is a positive experience for its members. Within the human services field, practitioners are expected to be competent helpers that provide the best possible care for their clients. In psychiatric rehabilitation education and treatment planning with clients, it is stressed that helpers need to be aware of all potentially beneficial treatment options and convey accurate information about these options to clients (Pratt et al., 2002). Allowing clients to consider all treatment options is seen as an important step in empowering clients and an integral part of the recovery model. As such, practitioners need to be aware that clubhouse can be a potentially useful component in their clients’ recoveries.

Furthermore, psychiatric rehabilitation training programs need to be certain that students are learning about all viable treatment options, including clubhouse. The inclusion of clubhouse in treatment planning and education programs could improve the quality of services rendered and positively effect treatment outcomes. Individuals with serious mental illness continue to experience high levels of stigmatization and low success rates. Any educational efforts that could assist practitioners or future practitioners
in aiding this group should be considered. The results of this study could provide valuable lessons into how recovery is put into action and examples of what the recovery process looks like. Use of this research can help practitioners and students gain a better perspective on the challenges that individuals with mental illness face and how they meet those challenges.

For Researchers

These results also hold implications for researchers. Since this initial investigation into the processes and experiences within the clubhouse yielded such favorable descriptions, it is imperative that additional studies be conducted. As previously noted, the individuals served by clubhouses have a long history of poor outcomes and any interventions that appear to better serve them should be further explored. The results of this effort can serve as a foundation for future investigations. These results can be helpful in guiding researchers in designing creative and meaningful investigation into what transpires within clubhouses. Importantly, any details that foster a greater understanding of what individuals with serious mental illness find helpful in treatment is invaluable and should be pursued.

Future Research

As previously noted, this research effort has attempted to fill a considerable gap in the current state of knowledge regarding clubhouses. The purpose of the investigation was to capture the clubhouse experience through the perceptions of its members. Since there has been no research into the processes within the clubhouse model, this research serves a foundation for future efforts. Because of this scarcity of clubhouse research and
in light of the complexity of interactions within them, there are innumerable avenues that could be explored.

Future qualitative investigation could provide information that may build generalizability through repeated similar findings or provide more in-depth understanding of some of the key concepts described by members. Interesting and informative pursuits could unravel what the essence of the so-described sense of “family” found within the clubhouses; the overall effects of “hugs and kisses” within clubhouse; or a deeper exploration of what “empowerment” is for clubhouse members. Many of the concepts touched upon in this project are deeply personal experiences that could benefit from further qualitative explorations.

Furthermore, a variety of other statistical analyses could examine the occurrence, quality, and effects of many of the reported activities. My findings outline a variety of activities that occur within the clubhouse. Specific efforts could look to quantify these activities. As examples, researchers could look to measure the frequency of peer support within clubhouse, its quality, and its effects, or a similar investigation of staff’s utilization of strengths-based interventions. Efforts to understand the effectiveness of the member-to-member outreach program or the success of their peer tutoring programs would also be interesting. Such efforts would help to better understand which components of the clubhouse are most effective in helping individuals toward recovery.

Additionally, studies could be designed that compare clubhouse to other programs. Investigations comparing the effectiveness of clubhouses’ skill-building programs to other more traditional training programs would be useful. Additional and broader efforts to examine vocational outcome measures for clubhouses and other
vocational rehabilitation programs would also be useful. And statistical measures of the reported member satisfaction within clubhouse, and comparisons to other programs would also be interesting and valuable.

More interesting and challenging, I think, would be research into how similar or different clubhouse is to other mental health counseling services. One of the interviewees explained that “there’s always room for counseling” at clubhouse and many others reiterated this sentiment, despite the clubhouse mission of being free from providing direct mental health services. Also, efforts to understand how clubhouse affects members’ insight into their mental illness and how this affects treatment compliance would be interesting and useful. Additionally, any longitudinal examinations of how members view clubhouse and its effects over the years would be immensely important toward understanding clubhouse across the lifespan and in relationship to each new treatment trend.
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Appendix A

International Standards For Clubhouse Programs

The International Standards for Clubhouse Programs, consensually agreed upon by the worldwide Clubhouse community, define the Clubhouse Model of rehabilitation. The principles expressed in these Standards are at the heart of the Clubhouse community’s success in helping people with mental illness to stay out of hospitals while achieving social, financial and vocational goals. The Standards also serve as a “bill of rights” for members and a code of ethics for staff, board and administrators.

The Standards insist that a Clubhouse is a place that offers respect and opportunity to its members. The Standards provide the basis for assessing Clubhouse quality, through the International Center for Clubhouse Development (ICCD) certification process. Every two years the worldwide Clubhouse community reviews these Standards, and amends them as deemed necessary. The process is coordinated by the ICCD Standards Review Committee, made up of members and staff of ICCD-certified Clubhouses from around the world.

MEMBERSHIP

1. Membership is voluntary and without time limits.

2. The Clubhouse has control over its acceptance of new members. Membership is open to anyone with a history of mental illness, unless that person poses a significant and current threat to the general safety of the Clubhouse community.

3. Members choose the way they utilize the Clubhouse, and the staff with whom they work. There are no agreements, contracts, schedules, or rules intended to enforce participation of members.
4. All members have equal access to every Clubhouse opportunity with no differentiation based on diagnosis or level of functioning.

5. Members at their choice are involved in the writing of all records reflecting their participation in the Clubhouse. All such records are to be signed by both member and staff.

6. Members have a right to immediate re-entry into the Clubhouse community after any length of absence, unless their return poses a threat to the Clubhouse community.

7. The Clubhouse provides an effective reach out system to members who are not attending, becoming isolated in the community or hospitalized.

**RELATIONSHIPS**

8. All Clubhouse meetings are open to both members and staff. There are no formal member only meetings or formal staff only meetings where program decisions and member issues are discussed.

9. Clubhouse staff are sufficient to engage the membership, yet few enough to make carrying out their responsibilities impossible without member involvement.

10. Clubhouse staff have generalist roles. All staff share employment, housing, evening and weekend, holiday and unit responsibilities. Clubhouse staff do not divide their time between Clubhouse and other major work responsibilities.

11. Responsibility for the operation of the Clubhouse lies with the members and staff and ultimately with the Clubhouse director. Central to this responsibility is the engagement of members and staff in all aspects of Clubhouse operation.

**SPACE**

12. The Clubhouse has its own identity, including its own name, mailing address and
telephone number.

13. The Clubhouse is located in its own physical space. It is separate from any mental health center or institutional settings, and is impermeable to other programs. The Clubhouse is designed to facilitate the work-ordered day and at the same time be attractive, adequate in size, and convey a sense of respect and dignity.

14. All Clubhouse space is member and staff accessible. There are no staff only or member only spaces.

WORK-ORDERED DAY

15. The work-ordered day engages members and staff together, side-by-side, in the running of the Clubhouse. The Clubhouse focuses on strengths, talents and abilities; therefore, the work-ordered day must not include medication clinics, day treatment or therapy programs within the Clubhouse.

16. The work done in the Clubhouse is exclusively the work generated by the Clubhouse in the operation and enhancement of the Clubhouse community. No work for outside individuals or agencies, whether for pay or not, is acceptable work in the Clubhouse. Members are not paid for any Clubhouse work, nor are there any artificial reward systems.

17. The Clubhouse is open at least five days a week. The work-ordered day parallels typical working hours.

18. The Clubhouse is organized into one or more work units, each of which has sufficient staff, members and meaningful work to sustain a full and engaging work-ordered day. Unit meetings are held to foster relationships as well as to organize and plan the work of the day.
19. All work in the Clubhouse is designed to help members regain self worth, purpose and confidence; it is not intended to be job specific training.

20. Members have the opportunity to participate in all the work of the Clubhouse, including administration, research, intake and orientation, reach out, hiring, training and evaluation of staff, public relation, advocacy and evaluation of Clubhouse effectiveness.

**EMPLOYMENT**

21. The Clubhouse enables its members to return to paid work through Transitional Employment, Supported Employment and Independent Employment; therefore, the Clubhouse does not provide employment to members through in-house businesses, segregated Clubhouse enterprises or sheltered workshops.

**Transitional Employment**

22. The Clubhouse offers its own Transitional Employment program, which provides as a right of membership opportunities for members to work on job placements in business and industry. As a defining characteristic of a Clubhouse Transitional Employment program, the Clubhouse guarantees coverage on all placements during member absences. In addition the Transitional Employment program meets the following basic criteria.

   a. The desire to work is the single most important factor determining placement opportunity.

   b. Placement opportunities will continue to be available regardless of success or failure in previous placements.

   c. Members work at the employer’s place of business.

   d. Members are paid the prevailing wage rate, but at least minimum wage, directly
by the employer.

e. Transitional Employment placements are drawn from a wide variety of job opportunities.

f. Transitional Employment placements are part-time and time-limited, generally 15 to 20 hours per week and from six to nine months in duration.

g. Selection and training of members on Transitional Employment is the responsibility of the Clubhouse, not the employer.

h. Clubhouse members and staff prepare reports on TE placements for all appropriate agencies dealing with members’ benefits.

i. Transitional Employment placements are managed by Clubhouse staff and members and not by TE specialists.

j. There are no TE placements within the Clubhouse. Transitional Employment placements at an auspice agency must be off site from the Clubhouse and meet all of the above criteria.

**Supported and Independent Employment**

23. The Clubhouse assists and supports members to secure, sustain and subsequently, to better their employment.

24. Members who are working independently continue to have available all Clubhouse supports and opportunities including advocacy for entitlements, and assistance with housing, clinical, legal, financial and personal issues, as well as participation in evening and weekend programs.

**EDUCATION**

25. The Clubhouse assists members to further their vocational and educational goals by
helping them take advantage of adult education opportunities in the community. When
the Clubhouse also provides an in-house educational program, it significantly utilizes the
teaching and tutoring skills of members.

FUNCTIONS OF THE HOUSE

26. The Clubhouse is located in an area where access to local transportation can be
assured, both in terms of getting to and from the program and accessing TE opportunities.
The Clubhouse provides or arranges for effective alternatives whenever access to public
transportation is limited.

27. Community support services are provided by members and staff of the Clubhouse.
Community support activities are centered in the work unit structure of the Clubhouse.
They include helping with entitlements, housing and advocacy, as well as assistance in
finding quality medical, psychological, pharmacological and substance abuse services in
the community.

28. The Clubhouse is committed to securing a range of choices of safe, decent and
affordable housing for all members. The Clubhouse has access to housing opportunities
that meet these criteria, or if unavailable, the Clubhouse develops its own housing
program. Clubhouse housing programs meet the following basic criteria.

   a. Members and staff manage the program together.

   b. Members who live there do so by choice.

   c. Members choose the location of their housing and their roommates.

   d. Policies and procedures are developed in a manner consistent with the rest of
the Clubhouse culture.

   e. The level of support increases or decreases in response to the changing needs of
the member.

f. Members and staff actively reach out to help members keep their housing, especially during periods of hospitalization.

29. The Clubhouse conducts an objective evaluation of its effectiveness on a regular basis.

30. The Clubhouse director, members, staff and other appropriate persons participate in a three-week training program in the Clubhouse Model at a certified training base.

31. The Clubhouse has recreational and social programs during evenings and on weekends. Holidays are celebrated on the actual day they are observed.

FUNDING, GOVERNANCE AND ADMINISTRATION

32. The Clubhouse has an independent board of directors, or if it is affiliated with a sponsoring agency, has a separate advisory board comprised of individuals uniquely positioned to provide fiscal, legal, legislative, consumer and community support and advocacy for the Clubhouse.

33. The Clubhouse develops and maintains its own budget, approved by the board or advisory board prior to the beginning of the fiscal year and monitored routinely during the fiscal year.

34. Staff salaries are competitive with comparable positions in the mental health field.

35. The Clubhouse has the support of appropriate mental health authorities and all necessary licenses and accreditations. The Clubhouse collaborates with people and organizations that can increase its effectiveness in the broader community.

36. The Clubhouse holds open forums and has procedures which enable members and staff to actively participate in decision making, generally by consensus, regarding
governance, policy making, and the future direction and development of the Clubhouse.

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425 West 47th Street
New York, New York 10036
USA
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October, 1989 ©
Revised as of October, 2006
Appendix B

Are you a Clubhouse Member?

You may be eligible to participate in a Penn State University research project about The Clubhouse Experience.

Your stories may help mental health workers and educators better understand how the clubhouse affects the lives of members.

Participation in this study involves a one-hour interview.

You will receive $10 for participating in the interview and all information will be kept confidential.

If you are interested in participating, please contact:
Gregory Roth, M.Ed.
(814) 863 – 6153
gxr100@psu.edu
Appendix C

INFORMED CONSENT FORM FOR SOCIAL SCIENCE RESEARCH

Title: The Clubhouse Experience

Investigators: Gregory Roth, M.Ed. Brandon Hunt, Ph.D., CRC, NCC
333 CEDAR Building 309 CEDAR Building
814/863-6153 814/863-2408
gxr100@psu.edu bbh2@psu.edu

We are asking you to take part in a research project that will look at the clubhouse experience. By hearing about how the clubhouse has affected you, we hope to gain a greater understanding of clubhouse programs. We will use all the information we gather to educate mental health professionals about clubhouse programs.

If you agree to take part in this project, you will be interviewed by Gregory Roth for about one hour, either in a place of your choosing or by phone. The results of your interview will be combined with interviews from 6-10 other people. The purpose of the interviews is to talk with you about your experiences within the clubhouse. These interviews will be audio taped, and you will be given the chance to review a written report of the interview and make any changes or additions. You will get $10 for doing the interview, even if you do not complete the interview.

The tapes and any other papers for this study will be kept in a locked office and no one will be able to see them except the researchers. Once the tapes have been changed to written reports and checked for mistakes, they will be destroyed. All tapes will be destroyed by August 2007. Your name will not be used on the tape or in any part of this study. Instead, an fake name, selected by you, will be used for the reports. Please note, the Office of Human Research Protections in the U.S. Department of Health and Human Services, the Office for Research Protections at Penn State and the Social Science Institutional Review Board may review records related to this project. In the event of a publication or presentation resulting from the research, no personally information that would reveal your identity will be shared.

This study involves minimal risk; that is, no risks to your physical or mental health beyond those seen in the normal course of everyday life. We do not think that you will experience any discomfort related to being in this study, but we are aware that you may be talking about personal issues related to your illness. If you feel any discomfort or anxiety, we can give information about where you can get counseling about any things that may come up because of your being in this study or you can call your own case manager or counselor.

You may ask any questions about this study. Your information will be kept confidential, meaning only the researcher will know your identity or any information that can be linked with you.
Your participation is voluntary. You are free to stop your part in the research at any time and you do not have to answer all of the questions. If there are some questions that you do not want to answer, just tell the interviewer.

By signing this form, you are giving your permission to be in this research project as an official part of the education and research program at the Pennsylvania State University according to the terms listed below.

- I understand the information given to me, and I have been given answers to any questions I may have had about my role in the research. I understand and agree to the terms of this study as described.
- To the best of my knowledge and belief, I have no physical or mental illness or difficulties that would increase the risk to me by being in this study.
- I understand that I will receive $10 for doing an interview.
- I understand that being in this research is voluntary, and that I may end my part at any time. I also know that I do not have to answer any questions that I do not want to.
- I am 18 years of age or older.
- I understand that I will receive a signed copy of this form.
- I agree to have my interview tape-recorded.

_____________________________________  _________________
Signature        Date

Researcher/Interviewer:

I certify that the informed consent procedure has been followed, and that I have answered any questions from the participant above as fully as possible.

_____________________________________  _________________
Signature        Date
Appendix D

Interviewee #:

Information to be Gathered by the Interviewer

Age:

Gender:

Ethnicity:

Relationship status:

Alias:

Years with mental illness:

Months as a member:

How did you come to be a member?

How has the clubhouse served you?

What have you gained from the clubhouse?

What is it that makes clubhouse different from other programs?

How is the clubhouse similar or different from other services?

How would you describe the clubhouse experience?

What do you think people need to know about the clubhouse?

How has the clubhouse affected your life outside of the clubhouse?

How has the clubhouse affected how you view yourself?

How has the clubhouse affected how you view others?

How has the clubhouse affected how you view mental health services?

What else would you like to explain about the clubhouse?
Dear

Thank you again for your participation in this research into the Clubhouse Experience. As we had previously discussed, I am asking that you review the written transcript of our interview for accuracy and thoroughness.

If you find that there are mistakes within the transcript or if you want to make changes, please contact me to inform me of the errors or you may add your own written comments to the transcript and mail it back to the address listed above.

If I do not hear back from you within two weeks, I will assume that you are satisfied with the transcript.

I greatly appreciate your time and effort in this important project.

Sincerely,

Gregory Roth, M.Ed.
Dear :

Thank you again for your participation in this research into the Clubhouse Experience.

As we had previously discussed, I have combined your interview with the interviews of other clubhouse members to create a description of the clubhouse experience.

If you think that my interpretation of the interviews seems inappropriate or inaccurate, please contact me to discuss your concerns. Any feedback regarding my interpretation of the combined interviews would be greatly appreciated. You may phone, email, or write to me about your feedback.

If I do not hear back from you within two weeks, I will assume that you are satisfied with my interpretation of the clubhouse experience. Thank you again for your effort and cooperation with this project.

Sincerely,

Gregory Roth, M.Ed.
Appendix G
The Essence of the Clubhouse Experience: The Participants’ Words

Clubhouses are community centers established to help individuals with serious mental illness. These community centers are specifically planned and designed to be warm, attractive, and inviting spaces that offer access to everyone. Individuals who join the clubhouse are referred to as “members” and the staff are typically referred to as “generalists.”

The centers primarily offer a unique version of vocational rehabilitation that emphasizes skill building through peer support. The centers are specifically structured to *not* focus on individuals’ mental illness, but instead have a purposeful focus on individuals’ *strengths*. Members are encouraged to engage in two different avenues of vocational rehabilitation: In-house volunteer work or Transitional Employment Placement (TEP) outside of the clubhouse. A minimal number of generalists oversee the centers, and as such, the in-house volunteer work is vital in maintaining and operating the centers. The in-house volunteer work is an important step in establishing work histories and in building the skills that may help members transition into “real world” job placements. Members are encouraged to “try-out” the different in-house duties that are needed to operate a community center. This may include assisting in meal planning, cooking, cleaning, clerical, recruitment, peer-training, peer-advising, peer-education, budgeting, and advocacy activities. When appropriate, members are welcomed to fill TEP position in companies throughout the community. The TEPs are typically cleaning, retail, or clerical jobs that last from 6-8 months. Additionally, clubhouses offer social activities and some offer comfortable and reasonably affordable housing.

Members benefit from this program in a variety of ways. At its most basic level, clubhouse provides members with a place to go and some structured activities. They have the opportunity to learn new skills that help them in both work and home lives. More importantly, the members
are provided with an atmosphere where they feel welcomed, safe, and free of the stigma that the public often associates with mental illness.

Members are assisted by well-trained and educated generalists who are genuinely invested in their work and in the well-being of the members. The generalists are wonderful individuals that are supportive, respectful, true to the word, and lead by example.

For its members, the clubhouse experience includes having a family-like sense of belonging within a friendly community that cares about and nurtures its members. Clubhouse members feel needed within a community where strong friendships can be built. Providing mutual support for one another allows members to interact in meaningful ways that help in building confidence, self-esteem, and a sense of empowerment. Having the shared experience of living with mental illness allows its members a greater sense of empathy and understanding for one another. The positive energy and continual encouragement helps the members define and move toward their individualized goals of recovery.

Clubhouses are places where individuals who have traditionally been discriminated against and mistreated can instead be treated with respect and dignity. They are places that individuals can feel good about themselves and help others to do similarly. Despite its non-illness focus, clubhouses assist its members in maintaining their mental health stability, while helping them to feel like happy, competent, capable, and contributing members of society.
Vita

GREGORY ROTH
rothgregory@hotmail.com

EDUCATION

B.A., Journalism, The Pennsylvania State University, 12/1990

WORK EXPERIENCE

Teaching:
Adjunct Faculty, Saint Francis University – Loretto, PA (8/2007 – 12/2007)
  PHTH 554 (Psychosocial Aspects of Client Care, Fall, 2007)
  - Taught 20 graduate students
  REHAB 412 (Professional Preparation in Rehabilitation Settings, Spring, 2007)
  - Taught 49 undergraduate students
  REHAB 408 (Introduction to Human Services, Fall 2006)
  - Taught 47 undergraduate students
  CN ED 562 (Current Issues and Ethics in Rehabilitation Counseling)
  - Co-taught 15 master’s-level students
Graduate Assistant (teaching and research), The Pennsylvania State University
  CN ED 501 (Counseling Theories)
  REHAB 410 (Psychiatric Disabilities)

Counseling and Community Mental Health Service:
  - Provided individual and group counseling services for adults with addictions and mental health issues
Counselor Supervisor (Practicum), CEDAR Clinic – University Park, PA (1/2006 – 5/2006)
  - Provided 1:1 clinical supervision for 2 master’s-level counselors
  - Provided 1:1 counseling services for PSU students
  - Provided case management and social worker services for injection drug users
  - Assisted in collection and organization of data for 2 NIDA-funded investigations regarding treatment strategies for injection drug users
  - Contributed writing and editorial assistance for related research products
  - Provided individual and group counseling services for adults with serious mental illness
  - Served as the Mental Health counseling specialist for homeless adults
  - Performed residential counselor duties for individuals with serious mental
  - Performed case management duties for individuals with serious mental