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**Abstract**
[Excerpt] The importance of high expectations has been well established as a tool in successful goal achievement and life advancement. The challenge for helpers is ensuring that this pressure of high expectation is initially borne more by rehabilitation staff members who are charged with assisting people with a psychiatric disability to realize success and not merely transferred through as an added burden to the clients they serve.

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# If Work Makes People with Mental Illness Sick, What Do Unemployment, Poverty, and Social Isolation Cause?

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Helen Keller, an icon of the disability rights movement, said: "People do not like to think. If one thinks one must reach conclusions; conclusions are not always pleasant." Much of the advocacy and professional writing (Anthony, 1994; Harding & Zahniser, 1994; Marrone, 1993; Strauss, 1987) in the psychiatric rehabilitation field over the last decade has been devoted to exploding the myth of hopelessness and irreversible decline attendant to the diagnosis of schizophrenia in people. One particular area of interest and research has been in the capacity of people with serious and persistent mental illness to work successfully. Not much attention, however, has been devoted to an exploration of the topic of this article, that is, if people with mental illness can work, then the obvious companion postulate is that people with mental illness should work. Disability advocacy for employment has emphasized the untapped capacity of people with significant disabilities to make a contribution to our society as citizens through working. The argument that people with disabilities can't work is essentially an empty one, as there are many examples that show that people with a wide variety of significant disabilities can work. The authors espouse the view that working is both a right and a responsibility for citizens with disabilities. Adults with disabilities are the only group in this country for whom not working has been considered an acceptable life-style.

The importance of high expectations has been well established as a tool in successful goal achievement and life advancement. The challenge for helpers is ensuring that this pressure of high expectation is initially borne more by rehabilitation staff members who are charged with assisting people with a psychiatric disability to realize success and not merely transferred through as an added burden to the clients they serve.

One cautionary note and clarification must be made. These arguments are not meant to do either of the following:

1] negate the real barriers (e.g., medical insurance, lack of meaningful career opportunities, fear of the unknown, history of failed attempts) or financial tradeoffs (loss of food stamps, Section 8 housing subsidies, special program supports) people with all disabilities face in leaving Social Security or Public Assistance rolls (SSI, SSDI, TANF);

2] Imply that an acceptable strategy is for professional helpers to adopt a *get tough* approach with people with mental illness who are scared or reluctant to attempt employment. In fact, the change from the role of patient or client to a new role as worker in society is fragile at best. The journey to employment requires a more sensitive approach from all involved individuals (the worker, the professionals, family, and friends) to the extent that everyone can successfully leverage the potential and ability of the worker with an appreciation of the limitations that are part of the illness.

The authors feel that finding the solutions to #1 and avoiding the inappropriate tactics of #2 are closely connected. Rehabilitation professionals and other helpers can do a better job in assisting people, advocating in their best interests, and accepting some risks in service to working on behalf of the people with serious and persistent mental illness that they are charged with serving. The limited use of the existing SSI and SSDI work incentives that have been in place since 1981 show that the disincentives are an important but not all-encompassing piece of the problem. The most egregious example is the almost nonexistent use of the Title 1619b provision that allows people on SSI in most instances to keep their Medicaid coverage while earning significantly more than what is considered full employment (in Massachusetts, that figure or "threshold" amount was approximately $24,000 in 1998). This, in the face of the fact that health insurance and health care benefits" are at the forefront of barriers to employment that consumers and advocates consistently cite.

The authors propose that ultimately people with disabilities do, in fact, have to accept personal responsibility to choose employment as part of the social contract of citizenship. Nevertheless, the answers do not lie solely within their purview. Rather, staff members must improve their capacity to inspire, aid, challenge constructively, support, and advocate for the people with whom they work. Staff members must also hold themselves more accountable for building their own competencies and achieving meaningful results vis a vis employment outcomes -- not accept mediocre results as justifiable because of the "severity of the disability" or the "system disincentives".

***People should work because:***

*Unemployment is much worse for your mental health than the stresses of employment.* No hard data exists showing that helping people move into employment (even nagging them into it) is bad. Van Dongen (1996) has made the case that work, rather than increasing stressors helps distract people from their symptomatology. People like Gary Bond (1998), Bob Drake, et al (1994), Russert & Frey, (1991) in their work have made a good case for employment as a necessary addition to current programs of psychiatric rehabilitation, notwithstanding the fact that employment has always been given "lip service" since the inception of the Community Support (CSP) movement (Turner & Ten Hoor, 1978). Even those efforts haven't been targeted on really encouraging and motivating people to choose work. Issues that unemployment, particularly long term unemployment, brings to the fore are depression, feelings of worthlessness, self - pity, self absorption, higher risk of substance abuse, greater chance of isolation, and poverty.

In preparation for writing this piece, one of the authors conducted an extensive literature search specifically for any clinical studies that showed the ill effects of employment on the mental health of people with serious mental illness. No such clinical research studies were found. There is a rather large body of existing data showing poor outcomes in psychiatric vocational rehabilitation, but no information regarding actual ill effects (in contrast to consumers' fears because of perceived or potential problems).

Clearly, much anecdotal material does persist in the field and cannot be discounted. However, the authors' point is that a widely shared concern about negative consequences attendant to working is not based on "hard" data and is contrary to admittedly limited, but nonetheless encouraging, findings about the benefits of employment. In essence what staff members do if they don't encourage people to work is advocate that they increase the factors that exacerbate, rather than ameliorate, their problems. When the individual says, "I can't go on this interview. I'm too scared that I won't get the job," the helper must be confident in saying, "What can I say or do to help you feel more comfortable about going on this job interview?" This conversation is risky but necessary. The relevant theme that resonates most strongly throughout the literature is that successful employment and positive mental health are essentially very different

domains. If anything, a stronger relationship exists between un- or underemployment and the occurrence or persistence of psychological problems, than with employment itself. Also, the potential for significant improvement in overall quality of life through work is quite real (Vanden Boom & Lustig, 1997).

*It's a responsibility of citizenship -- It's "part of the deal."* It's a right that people should enjoy. People with mental illness have become increasingly concerned, as they rightly should, about issues of civil rights and citizenship and empowerment. A major component of the civil rights movements in the U.S. - whether focusing on racial equality, gender, age, sexual orientation issues, the union movement, or the ADA - has been around *freedom to gain access to*, not *freedom from* employment. It is somewhat disingenuous to rightfully demand respect and dignity as a person beyond the label of serious and persistent mental illness, yet expect to be free from the obligations and expectations of full citizenship in our society. Once again, if we accept the premise that people with mental illness can work, then it seems we should move naturally to the concomitant proposition that people with mental illness should work. People often say that it is up to the person to choose if he or she wants to work. To those who suggest that, three thoughts are offered:

1] We often restrict people's ability to choose things. For example, discussions abound, about people who have "unrealistic" career goals, who expect us to get them high paying, career jobs although they lack the requisite skills. Or, even more dramatically, consider the person who develops a romantic attachment to a helper and wants to have intimate relations with him or her.

2] The authors would challenge the readers of this piece to go home tonight and sit down with their spouses, lovers, roommates, or adult children and announce to them that they have chosen not to work anymore. Our assumption is that the spouse, lover, etc. would not treat this declaration neutrally with a response of "Whatever you decide, dear" but rather would have a firm opinion about the feasibility of that option.

3] Access to employment in U.S. society is both a right and a responsibility. Citizens are expected to be productive and participate in a society integrated by race, gender, age, ethnic origin, and disability. Because the U.S. is a free society, the government cannot mandate that everyone feel this way. But societies are governed by laws and publicly stated values (in the U.S., the Constitution, Declaration of Independence, Civil Rights Act of 1964, Title IX, and ADA are prominent examples). The psychiatric rehabilitation funding agency or provider is part of a broader community context, whose values and actions are guided by public law and regulation. It cannot force its clients, or any other citizens, to embrace employment and integration. However, it can wholeheartedly endorse, in statement and action, policies that support these two principles because as a public and community service entity, it must reflect the core social values of the society of which it is a part. It is incumbent upon any funding or community service agency to clarify what activities it wishes to support and encourage -- not merely to identify what it will tolerate.

*Work is not enough in a person's life, but it's a better start on the rest of the "American Dream" than unemployment and poverty.* Billie Holiday has stated most succinctly that: "You need a little love in your life and some food in your stomach before you can hold still for some damn fool's lecture about how to behave." Clearly, there are many aspects of a person's life that influence quality of life other than employment, for example, physical and mental health, intimate relationships, friendships and social networks, spirituality, children, and the quest for meaning and self - identity. However, one would be hard pressed to argue that staying in the state of unemployment and poverty enhances

a person's access to or capacity for these other dimensions of a quality life. Yet, this is essentially what we, as helpers and advocates do, when we recommend against or don't actively promote pursuing employment for people with mental illness in the face of possible stressors inherent in that choice. Successful employment does not guarantee satisfaction or fulfillment in other arenas. This fact should not mitigate our efforts to help people master this aspect -- if for no other reason that this is at least a concrete area that helpers can measure and affect positively. Other more ephemeral elements, while no less, and sometimes more important, to individual quality of life are much more resistant to the attentions of community rehabilitation professionals.

Jobs should not define the totality of the meaning of "success" for people with disabilities any more than they should be seen as definitive standards for achievement by others. Purely person-referenced outcomes like happiness, enjoyment, and contentment are things that service providers should hope to inspire within the people they serve, but nevertheless are outside the bailiwick of the results for which they can logically be held accountable. The basis for the funding of community rehabilitation providers is to help their consumers with disabilities improve their life situations vis-a-vis employment and income. Providing rehabilitation services without using improved vocational performance goals as indicators seems spurious. Providers' contracts from funding sources should contain the outcomes desired, and subsequent fiscal allocations should be subject to modification based on program goal achievement and adherence to some recognized local, national, or international standards of good practice.

*Getting a job quickly is more likely to lead to a career than just planning.* It is crucial for people with serious mental illness to be helped to achieve both rapid employment entry and career development and growth opportunities within the labor force. There is often a presumption that good planning naturally leads to actions in service to those plans. This seemingly logical progression of events is not the norm in planning whether viewing the lives of people with disabilities (Ferlenger, 1995; West & Parent, 1992) or those without disabilities (Hagner & Marrone, 1995; Hahn, 1991; Jenkinson, 1993). People who have not partaken of early educational and vocational experiences or whose communication skills are impaired often are "novice decision-makers" (Biersdorff, 1995) vis-a-vis life planning. People with disabilities, often under the guise of protection, are held to higher standards of skill development before choices are accepted than others in the community (Jenkinson, 1993).

Just as important as assisting people to dream and think about careers is helping them develop an understanding of an essential fact of worklife -- a person cannot have a career without a job. All the insight, dreaming, visioning, positiveness, and planning in the world will not give anyone, including a person with mental illness, a foundation to a career without a concomitant focus on gaining relevant work experience. The same is true of the opportunity to develop contacts that can only be nurtured in the context of mutual business, as well as personal interconnectedness and self - confidence and energy that comes from participating in a world much wider than the protected sanctuaries of psychiatric rehabilitation or clinical day services. The continued importance of education and lifelong learning of all sorts, whether in supported education or not, cannot be minimized in terms of ultimate career development. If one has a clear career goal (for example, lawyer, doctor, researcher) or lacks minimal educational credentials (for example, GED) then it may be advisable to pursue educational opportunities more than work experience. However, in the absence of such a compelling need, then the person with a mental illness and his or her advocates should strongly consider real world work experience a key tool to use in career planning.

*It does not get easier later on.* Delaying entry into the work force does not make job entry easier. While people with serious mental illness certainly need more support than merely job and skill acquisition to make a smooth transition into employment (Marrone, Balzell, & Gold, 1995), helping people move rapidly into employment does not appear to be deleterious to the mental or emotional health of clients with serious mental illness. The longer people delay their vocational aspirations, the more danger they face of insufficient work experience for career advancement, age discrimination, concerns raised by interviewers of unexplained or atypical career paths, and lack of exposure to information technology that permeates much of even the entry level modern work force. Indeed, rapid job entry instead of step-by-step adjustment even holds the potential of greater success and fewer negative consequences (Bond & Dincin, 1988).

Perhaps there would be more concern about "pushing" people too rapidly into employment and too narrowly equating life success with work success, if there was any tendency in the community psychiatric rehabilitation world to do so. However, the overwhelming preponderance of evidence over the last few decades is that rather than consumers' moving too hastily into employment options, the opposite is true. The pace of vocational achievement in even the most stellar psychiatric vocational rehabilitation programs seems quite lethargic in comparison to the employment and training program results considered successful with people without disabilities. Historically, these lower standards of achievement have been ascribed to the reasons cited earlier, such as "severity of the disability" or the "system disincentives." Perhaps it is now time for staff members to consider the possibility that in addition to these well established stumbling blocks, other blocks exist in the nature of minimal expectations for achievement, diminished capacity for hope and positiveness, and lack of systemic accountability for poor performance of staff members and programs.

*Employment is a more dependable and less stressful way of life than SSI, SSDI, or TANF benefits.* It is obvious that employment brings stresses and psychological strains, no matter the weight of the relative contribution or problems that these bring for a person's mental well - being. As noted earlier, there has been a great deal of attention paid to this potential problem, even in the face of little evidence of pernicious effects of employment. Much less, if any, discussion is found about the obvious fact that depending on the public system to equitably treat people with mental illness who are also poor, is just as risky, (or, as the authors would submit, more risky) than a job. Particularly in the current conservative climate dominating the political culture and the nation - wide challenge of "welfare reform" and "benefit roll reduction", the status quo is increasingly tenuous and fraught with uncertainty for people who rely on the provision of public human service delivery. Since political trends ebb and flow, perhaps a more important consideration is the fact that a person's choice to maintain the current situation in his or her life does not ensure that other elements do not fluctuate. Even people who have consciously chosen not to move ahead in a rehabilitative fashion may still face the variety of crises that are prevalent and, for some, inevitable in everyday life for people with few economic resources -- for examples, human service program staff turnover, poor health, loss of loved ones, eviction, and the aging process and attendant feelings of mortality. The status quo of unemployment and poverty does not make people impervious to changes out of their control; rather, it makes them more susceptible to having these life challenges taking a greater emotional toll.

*It's a way to meet people and expand social networks* Work acts as a training opportunity for the enhancement and development of social skills. Bellack & Mueser (1993), Lieberman, (1989), and Mosher & Burti (1992) all have amply looked at social dysfunction and performance and their impact on independent living. Yet the idea of

work as a viable training environment for social skills development is as obvious to some outside the field of rehabilitation as it is not understood by many who do work in the field. In a recent interview, an assistant professor of economics at MIT discussed her success in her field by saying, " It's very difficult to be told that you have a lot of potential when you're still in the process of achieving things; I'm still learning how good I am and what I can accomplish." When work makes you feel good about who you are and what you can do, then your desire to connect with others and to be part of larger communities of people is stimulated.

With time, work provides its own safety net for people. But a strong network of services and supports must be developed in order for individual rehabilitation and vocational goals to be reached. The support needed and provided by co-workers can elevate the employment experience from one of familiar isolation to one of relatedness and comfort. Individuals come to work because of the people with whom they work, not just for the job that needs to be done.

The skills learned and developed during times of employment - managing stress and uncertainty, communicating with others, delegating symptoms to a place of less influence and importance - will be helpful during times of unemployment. It is a normal part of a working life to be unemployed at times. But it is unhealthy and counterproductive to become or to be allowed to become demotivated because of this experience. Returning to pre-employment situations (isolation in an apartment or a return to a psychosocial day program) will not aid the recovery process. Any other understanding of how employment aids the recovery process should be carefully negotiated and discussed with the individual and should be seen only as a transitional state between jobs.

*It gives people more status than the "consumer" role.* The status of "consumer" envisions somebody who *takes*, gorging on the metaphorical meals served by the "system": supervised housing, financial subsidies such as SSI and SSDI, medication clinics, and other highly structured and dependent relationships with the mental health system. But successful and happy people don't just take; they give, not only to themselves, but to a larger community Or as Winston Churchill said, "We make a living by what we get. We make a life by what we give." Work provides status in our culture. To say, "I'm not working" raises questions and assumptions about who you are, or are not. Work carries value and status.

The stigma of mental illness remains a constant despite professional campaigns to eliminate it. A recent example of its endurance lies in the wake of the recent Capitol Hill shootings by Rusty Weston. In an editorial published August 10, 1998 in the Richmond Times Dispatch, it was commented that, "Rusty Weston, the Capitol gunman is by all accounts stark mad...And how could he afford the luxury of being a full time national nuisance? Like millions of other able bodied Americans, Weston draws disability pay...Disability pay ought to be reserved for those who are physically disabled - not those whose mental instability merely limits their employment options. Individuals truly disabled by mental illness should be in institutions - where they can't play gun games in the Capitol...Weston might never have been in Washington last month if he'd been locked away or obligated to work. The best tribute Congress could pay to his victims would be to stop enabling the lunatic lifestyle." (p.14). These simplistic comments raise several important issues and fascinating questions related to work and mental illness. While seemingly dismissive of the disease of mental illness and the power of its symptoms, and at the same time elevating the influence of work to curative in nature, we have to appreciate the worth and need for more discussion, particularly when

the term "lunatic" survives without apparent awareness of the stigma associated with that word.

Overprotectiveness in the name of public safety, or gratuitous concern and caring for those less fortunate, becomes a form of oppression and stigma in and of itself -- preventing growth, independence and opportunity for the individual most in need. As C.S. Lewis said, "Of all the tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive." Until individuals living with mental illness are part of a work force, attitudes associated with stigma such as repulsion and pity for the "mentally ill" will never be replaced with some tolerance or even acceptance. A new view and a new paradigm for integration remain elusive. But one connecting and healing thread remains intact: employment is healing and recuperative for anyone, regardless of the disease of mental illness. Employment clearly has status in our culture. As noted in by Radin (1997): "having a job is critical to a feeling of being seen as a contributing member of our society " (p. 17).

As "consumers" become "workers", the need for intensive case management and outpatient services becomes only significant as a service to be accessed when needed and necessary. This abandonment of the traditional locus of care, from a formalized mental health system to an individual empowerment model where work becomes an expectation, often precipitates defensive posturing around issues of setting up the client for failure, or the need to go slowly to make sure that the client will not decompensate.

People have dreams of careers, have struggled through a career, and have skills and abilities. As more individuals are living longer with their mental illness without the institutional experience of decades ago, the connection with work becomes more reasonable, more available as an option, and more of an expectation. The individual is usually ready. He or she has been waiting, and waiting for a long time for that opportunity to be, or again be, successful and to feel good. Even though these feelings of status and worth may not be immediately available, somehow, with support, most individuals know it is the right thing to do.

*It's a way to help people develop possibilities for intimacies, love, and sex.* The development of meaningful and reciprocal relationships is a hallmark of adult adaptation and functioning. As new workers negotiate their complex relationships with employers, coworkers, and the larger community, then the outcomes of intimacy, friendships, and reconnections with family become more satisfying options. Trust is not an instinct with which we are born. It is earned and carefully negotiated. Many individuals living with mental illness have developed a lack of trust and a skepticism of most professional interactions based upon years of dealing with a mental health system that often prompts disappointment and discouragement. Establishing rapport that is reliable and affirming is critical for the individual and the job coach.

In an article titled "The Connection Gap," Laura Pappano wrote, "More than ever, our lives are lived with fewer important connections. More of us live alone, eat alone, watch TV alone. We marry later and divorce more often. We work more. We travel solo, eat at the bar alone, and go to the movies by ourselves. We bank and shop by phone. We look for love on the Internet. And we don't visit anymore on Sundays. No wonder one-third of Americans tell pollsters they are lonely" (p.14). She talks about the lack of social interactions that "create social capital and trust among members of a community" (p.20), concluding that 'Reconnecting is critical for our survival, both as individuals and as a society" (p.23). The work experience begins to bridge the loneliness of living with a mental illness and the need to develop reciprocal and trusting relationships.

*There is more to do in your life.* To create a limited vision of what individuals with mental illness can and cannot do because of their disability only wastes the gift that is human potential. The shift away from a formal mental health system to a health system responding to each person's basic needs -work, love, shelter, food - requires a dialogue between competing viewpoints and values that are struggling to be heard and debated. Any person's life is more that just eating and sleeping. But for individuals living with mental illness, these two functions are often prominent in a daily repertoire of activities. Add to these, such diversions as watching television and smoking cigarettes, and you often have an accurate snapshot of "patienthood". The artificiality of day treatment centers, clubhouses, visits to the medication clinic, or to a therapist does not necessarily assist an individual with integration into a "normal" life. And for many individuals, these experiences are further clouded by the growing use of alcohol and illegal drugs, creating the "dually diagnosed patient" (Fowler, 1998; Minkoff and Drake, 1991).

Mental illness is a disease of losses. The individual can lose his or her family and friends, housing, income, appearance, skills, self-respect, and most importantly, hope. Employment can limit these losses and provide an opportunity to do and enjoy more in life. There is mounting empirical support for the idea that improved functioning in one area does not necessarily balance with improvements in others. Thus, getting a job may not automatically translate into good social skills. But certainly the development of employment - based interpersonal relationships often involve finding closeness and love, enhancing life, and fostering opportunity.

*To work, helps make each day more interesting plus leisure time then has more meaning.* Work and working are inherently more interesting and fulfilling than hanging around a drop-in center or reflecting incessantly on one's own life. While the functional limitations of mental illness can interfere with obtaining or retaining a job, the actual pursuit of a job becomes a daily conversation with oneself and with one's support network. As the worker feels more empowered to work, to look for a job, to set up an interview, and to accept a job offer, then achievement is absorbed into a daily routine. Each day takes on a cumulative dignity and provides a sense of belonging.

In tandem with working, leisure then has more meaning. Early on in the disease, the pursuit of purposeful leisure activities is lost and estranged from daily life. As self esteem and awareness are improved through work, the individual can benefit from an increased curiosity about what to do with more money, days off, and new friends. Work serves as a prompt for the new and interesting opportunities to plan vacations, organize breaks with co-workers and socialize after work with a cup of coffee or a beer. Identity and self expression are developed and fostered, creating a new life that is exciting, scary, depressing, and *interesting*.

*Working provides a distraction from illness.* The distractions offered by medications, therapy, counseling, and community treatment often serve as diversions from creating a fulfilling life. While important and unavoidable for many, they are inadequate in improving quality of life or in at least affecting some long term and meaningful gain in and of themselves. Employment ("working for a living") is more formative. The processes of talking about going to work, searching for a job, interviewing for a position, and keeping and losing a job, are cumulative in terms of facing a truth about expectations and dreams. Life's depth of field becomes sharper and more focused to the individual worker. The worker's relationship with others becomes more integrated and self curative. Service providers must appreciate the limiting effects of protecting the individual from stress (and the attendant fear of their own professional failure as a caregiver if the client decompensates). The client's shift in consciousness from illness to work issues enhances and supports the recovery process.

People who work worry about their job. Will I do it right? Will my co-workers like me? Will I lose my job? These are legitimate thoughts when so much is at stake. And these worries distract from the usual symptoms of mental illness. When there is something to look forward to or be afraid to lose, when you have a dream to hold onto, then you are distracted, at least temporarily. Working is an intimate experience; it sustains a sense of being and, within our culture, it identifies a contributing member of society. In balance, these new anxieties might be more manageable than the symptoms and negative behaviors that would need to be managed if work was not part of daily life.

Much literature supports guarded expectations around the ability of individuals with mental illness to handle the stresses of competitive employment and independent living (Blankertz, 1994; Ferdinandi, 1996). Lamb (1986) has said, "We all want chronic schizophrenics to experience the heightened self esteem and gratification that a life of employment, of feeling needed, and of being productive provide...[T]he clinical reality (is) that most chronic schizophrenics cannot handle the stress of competitive employment, and that, for the minority that can, entry-level, low stress jobs should most often be the goal. Otherwise, we simply give the patient another experience of failure and further lower his self-esteem." (p. 355). Much thinking about impairment and handicaps has changed in the intervening years. The person is no longer the disability, so that the chronic schizophrenic is today an individual living with the disease of schizophrenia or with a disability; the supported employment movement encourages client choice and entry at a level that is more akin to expressed desires. Stress, as noted in the beginning of this article, does not lead to decompensation or hospitalization, in and of itself. The concept of failure is only relative to the experience of trying something new. Success can be measured secondary to processing a job loss and not projecting an "I told you so" or "He isn't ready to work" attitude. Can self esteem become any lower that it was when the individual began some steps towards employment, even if he or she eventually loses a job? There is more than a dollop of disingenuousness in citing consumer and family apprehension as an insurmountable barrier to community employment. It is part of the responsibility of staff members to assist the individual and family in understanding what community employment is and how dismissing the concept out of hand will negatively impact the individual's life.

The actual words of these new workers are filling the ears of vocational rehabilitation staff members. The voices that they are hearing are from the customers that they are waiting on in a department store, not from inside a secret world in their head; the visions they see are not transitory and frightening, but they are their co-workers in the break room talking about getting more money or sharing complaints about a supervisor; the paranoia that others, the unknown, are out to get them, is replaced with being unappreciated by their bosses and why can't they get a raise in pay. Their stories are real, and they are welcomed distractions from a usual collection of negative symptoms and behaviors that had previously supported a lonely and isolated existence.

As employment for individuals living with mental illness becomes an acceptable norm and expectation, then the barriers of stigma, class bias, and discrimination diminish. The proof that individuals can work and should work is as *apparent* as the myth that the disease of mental illness precludes vocational growth is *transparent*. It is not acceptable or ethical that the potential value of one individual can be diminished by a disability. We must support the right to work with a knowledge that work is inalienable to the privilege of being a citizen.

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