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How Early Stigmatizing Experiences, Peer Connections, and Peer Spaces Influenced Pathways to Employment or Education After a First-Episode of Psychosis

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Abstract

This study illustrates how young adults experienced self-stigma in response to a psychosis diagnosis in young adulthood and how this delayed their career pathways. Natural peer support was critical in restoring self-identity and career pathways among young people with first-episode psychosis. Study findings have implications for improving Coordinated Specialty Care practice to include peer-based and other anti-stigma interventions for young adults with first-episode psychosis.

Introduction

First-episode psychosis (FEP) most commonly occurs in early adulthood, which coincides with the critical developmental transition from high school to college and the labor market (Mueser & McGurk, 2004; Rowland & Marwaha, 2018). An onset of potentially severe illness during this period can remove young adults from participation in educational activities and the labor market, leading to disability, prolonged unemployment, and poverty during the transition into adulthood (Agerbo et al., 2004; Baron & Salzer, 2002; Sylvestre et al., 2018). Social Drift Theory posits that as psychosis emerges during the period of young adulthood, time away from developmentally normal work and school settings results in "a lack of opportunities to accumulate human capital" (Funk, Drew, & Knapp, 2012, p. 172), reduced productivity, and loss of employment and earnings (Lund, 2012), which may lead to poverty and often, permanent disability. The psychiatric paradigm shift toward early intervention for FEP, including Coordinated Specialty Care (CSC), has shown promise in reducing disability for this population due to a focus on supporting employment and education in early stages of treatment (Killackey & Allott, 2013). Considering the critical need for poverty prevention among this group, it is an urgent research priority to learn how young adults with FEP negotiate employment and/or education and how interventions can facilitate this process. This paper presents results from a larger project that explored the ways in which trajectories toward employment, education, and disability form during the early stages of living with psychosis.

Background

First-Episode Psychosis, Employment/Education Disruption, & Disability

FEP can negatively impact vocational identity and aspirations when resulting in education or employment breaks (Birchwood & Fiorillo, 2000). It is common for young adults to experience unemployment in the months preceding the FEP as well as for prolonged periods while stabilizing from the illness (Ramsay et al., 2012). Educational disruption is also common, with college drop-out rates between 80–90% (Shinn et al., 2020) during the initial FEP period. Finally, the diagnostic labeling process can produce self-stigma, negatively impacting self-concept and personal aspirations (Ahmendani, 2011; Crocker, 1999; Goffman, 1959; Lauber et al., 2005), and further hindering pursuit of employment and education.

Furthermore, in the wake of FEP, a young person and/or their family and mental health providers may opt to apply for the financial support of disability benefits, if they are unable to work due to managing their illness. However, this often results in lengthy time periods spent unemployed and disengaged from career and/or education activities which creates a risk factor for poverty (Baron & Salzer, 2002; Cook, 2006; Krupa, et al., 2012). Few studies examine the ways that disability identity forms in individuals with mental health conditions. Estroff et al., (1997) found that psychiatric hospital staff or family often suggested disability benefits, which led to the individual taking on an impairment/dependence role rather than seeing themselves as employable. This social construction of disability through narratives of mental health professionals was also found in the previous paper from this study on FEP adults (Blajeski, 2020). Williams and Collins (2002) found that the "construction of the disabled self" resulted from an intersection between family, others who have experienced mental illness, mental health professionals, and society (p. 302).

Coordinated Specialty Care & Employment/Education

Given the challenges associated with disability from a FEP in young adulthood, the pathway to gainful employment can be challenging without interventions that target reengagement with employment and/or education. CSC programs for those with FEP are increasingly common in the United States (Heinssen et al., 2014; McFarlane et al., 2010; Melton et al., 2013) and operate under the premise that intervention during the "critical phase" consisting of the first 3-5 years of illness onset is essential to mitigate adverse outcomes (Birchwood & Fiorello, 2000). CSC includes clinical treatment modalities (e.g., individual and family psychoeducation, cognitive-behavior therapy for psychosis, case management, psychopharmacology), vocational support services, and, increasingly, peer support (Bello, et al., 2017; Melton, et al., 2013). There is a growing body of research suggesting the critical impact supported employment and education services have on both engagement in CSC (Lucksted et al., 2015) and outcomes, with approximately 60% of participants employed or enrolled in an education program upon exiting CSC (Nossel et al., 2018; Rosenheck et al., 2016). However, 40% of young adults exiting CSC programs remain on disability benefits rather than pursuing employment and education (Rosenheck et al., 2016) indicating a need for further study of how FEP influences employment and education pathways for young adults.

In summary, a young adult with a FEP is navigating both an illness and their own self-concepts and aspirations, which are in turn influenced by family, mental health professionals, and society during this crucial time. More research is needed from the perspective of young adults about their pathway between a FEP and returning to and/or initiating employment and education or disability pathways. The research questions included: 1) What key moments during an early psychosis pathway appear to shape the self-concept, aspirations, and expectations, and ultimately, direction toward working/

career or disability status among young adults? 2) How do these key moments appear to be influenced by contact and messages from others such as service providers, family, and friends? 3) What larger societal/structural themes appear to influence either employment or disability trajectories and how have these been experienced by these individuals?

Methods

This study was part of a larger qualitative research project (Blajeski, 2020) examining the social construction of illness, disability, and return to employment from the perspectives of young adults who experienced an FEP and had enrolled in CSC. The project relied on research questions drawn from the literature as well as Feminist standpoint epistemology, which considers 1) the sociopolitical and cultural contexts that influence the research; 2) rejects value neutrality of the researcher; and 3) starts from the position of the marginalized (Garrow & Hazenfeld, 2015). The parent study used a critical case design to select and conduct in-depth interviews with a specific sample based on key characteristics and conditions to deeply learn about a specific phenomenon (Patton, 1990), in this case the experience of returning to work and school among CSC participants. The Institutional Review Board at the University of Washington approved this study.

Study Setting

Early Assessment & Support Alliance. The Early Assessment and Support Alliance (EASA) early intervention for psychosis CSC program is offered throughout the state of Oregon and consists of 29 regional mental health centers and a university-based Center for Excellence. EASA is a nationally recognized leader in CSC practice and annually serves roughly 500 individuals aged 15–25 years who are experiencing FEP in Oregon. (Melton et al., 2013).

The Young Adult Leadership Council. EASA's Young Adult Leadership Council (YALC) was created in 2013 to provide a mechanism for CSC participants to be involved in statewide decision-making. Utilizing participatory decision-making, and emphasizing the importance of lived experience, YALC participants engage in public speaking about psychosis to a variety of audiences (e.g., legislators, employers, students), develop education materials, and advise on new EASA program policies and practices (Early Assessment & Support Alliance, 2018). EASA participants and program graduates can apply for membership at any time for six-month terms. YALC is consequently composed of 10-15 members who assemble from various regions of the state for monthly meetings held in a conference room provided by Portland State University.

Sample & Eligibility

A critical case sampling plan was deployed to locate a case that would "yield the most information and have the greatest impact on the development of knowledge" and "make[s] a point quite dramatically or [is] particularly important in the scheme of things" (Patton, 1990, p. 236). The YALC was chosen as the target for this study due to members' lived experience with FEP, past involvement with CSC care, and experience initiating, returning to, and/or struggling with employment or education. Ten EASA YALC current or former members were recruited. Inclusion criteria were: (1) at least 18 years of age, (2) have lived experience of an FEP, (3) completed a CSC program, and (4) able to provide consent.

Recruitment. The study's primary investigator attended one YALC meeting to describe the study and recruit participants. Interested YALC members shared their contact information with the researcher after the meeting. The researcher followed up by text message to screen for inclusion criteria, obtain consent, and schedule the first interview. Consent forms included a description of study purpose, investigator affiliation, and emphasized that the decision to decline or participate in the study was both voluntary and confidential. During the time of consent, the lead author explained the study procedures, allowed for questions to check for understanding, and assured that the young adults had the time they needed to consider their participation. Confidentiality risks were reviewed and participants were assured that their name and contact information would not be linked to their interview. Consent procedures were followed by an assessment of mental clarity and orientation to place where the researcher checked for understanding of the study and study question areas before commencing the interview.

Participant Characteristics. All 10 recruited participants completed the two-part interview series. Participants had a mean age of 26 (SD = 1.60) and were an average of 5.7 years post-FEP at study enrollment. None were current EASA participants, eight were current YALC participants, and two were past YALC participants. Participants were 50% male and 50% female; 70% were white, and 30% identified as racial/ethnic minorities: one Mexican-American, one Asian/Pacific Islander, and one Asian-American. See Table 1 for participant employment, education, or disability status at enrollment. Three participants were currently enrolled in post-secondary education and employed; three were employed full-time and not enrolled in an education program; one was employed part-time; and three were unemployed and had never been employed, one of whom was in the early stages of pursuing higher education. Four participants received Supplemental Security Income (SSI; $750/month at the time of the study), none of whom were working and two of whom were enrolled in a post-secondary education program. One participant was newly considering applying for SSI after a lengthy unemployment period. Pseudonyms are used for participants in this manuscript.

Table 1: Demographic and Employment Characteristics of Sample

Age at FEP	5 Years Post-FEP	Family SES	Activity Prior to FEP	Time Unemp./ Not in School	Current Occup.	Disability Benefit
21	8	Low	College student	9 months	Healthcare Intern	Yes
16	7	Low	High school	Never employed	Unemployed	Yes
21	6	Upper	College student/ part-time work	6 months	3rd-year law student	No
20	5	Middle	College student/ part-time work	9 months	Full-time peer specialist/family business	No
21	2	Middle	College student	3 months	Full-time peer specialist	No
21	6	Upper	College student	36 months	BA completed, working part-time	Yes
19	9	Middle	Part-time work	6 months	Full-time peer specialist/part-time college	No
19	6	Middle	High school	Never employed	Unemployed	Yes
22	3	Upper	College student/ part-time work	3 months/7–8 months with grandparents	Full-time insurance industry	No
23	5	Middle	Working full-time	Varied attempts at part-time work	Unemployed	No but applying

Data Collection

The researcher used a two-interview series of semi-structured interviews to elicit rich description of participants' perceptions and experiences (Denzin, 2017). Initial interviews collected demographic information (e.g., economic status, racial-ethnic background, and age of psychosis onset) and explored work or education status, history and goals, service experiences, and perspectives on what helped or hindered work and school engagement over time. Example questions are included in Appendix A. The second interview, which took place two to four weeks after the first interview in order to give the researcher time to analyze the initial data, clarified and expanded upon data gathered in the first interview. Participants were paid $75 after completion of the second interview as compensation for their time and contributions.

Interviews took place in a researcher-participant mutually-agreed-upon safe and private location, including participants' homes, meeting rooms at the local university or library, or a park. Interviews were audio-recorded using a handheld recorder, and the researcher also kept written notes. Both the primary researcher and a transcription service transcribed the interviews.

Data Analysis

Data was analyzed by the lead author using a template approach. This technique was used to organize themes into groups provided by the conceptual model and include emerging themes (Crabtree & Miller, 2002). First, the researcher coded all interview transcripts for key moments reported at the individual level, those from family and mental health professionals, and societal/structural level themes. Second, the researcher added emerging themes into a second document. Third, the researcher diagramed both a priori and emerging themes to illustrate timelines and relationships between themes and identify patterns across participant experiences. Fourth, the researcher transferred the organized themes into to a final codebook. To increase trustworthiness and validity of findings, the researcher invited participants to a focus group following analysis of all completed interviews to discuss emergent themes (Nowell, et al., 2017). Five participants attended the focus group and agreement was reached across all themes.

Three additional authors were invited to review the data presented in this paper: a community-based FEP researcher, a former participant of this study with lived experience of psychosis, and the director of the state-based CSC program. All authors met to review these themes, discuss specifiers and meaning, until they ultimately reached agreement on final themes.

Results

When asked about key moments that impacted their pathway to employment, education, or disability, 50% of participants described barriers brought on by their very first psychiatric treatment experiences, including being treated in stigmatizing ways by treatment providers, and the diagnostic labeling experience itself. These negative experiences planted the early seeds of mental health stigma that these young people would need to overcome to see themselves re-entering the world of employment or career. 60% discussed the difficulty in being in developmentally normative social settings (e.g., work and school) due to feelings of self-stigma. Connecting to peers who were also CSC participants provided critical social support and validation, as well as inspiration and role modeling. Through these peer experiences, participants integrated the psychosis experience into the everyday in order to return to employment or education. Participation in YALC further increased participant self-confidence in returning to or initiating career pathways.

Hospitalization & Psychiatric Labeling Construct Stigma

Participants detailed their personal experiences with the hospitalization that occurred early in their FEP period and felt that these key moments represented the first turning point in their pathway to employment, education, or disability.

> *I mean when you're in the hospital, the way you're treated, you're not treated the way you would normally treat someone in the grocery store or like a quote-unquote normal person, you're treated less-than, you're treated inferior than, and so it's really difficult to come out of that situation and then try to interact with other people, I mean my social skills went out the window after the hospital, the second time, because I was in the hospital for a month I felt like I didn't know how to socialize with people, it took a long time for me to get back to the point where I could like talk to people in a normal way. I think a huge part of my experience was that sense of not being treated like a normal person would be when I was in the hospital.*
> *– Jessica, age 25*

Jessica's early experiences with "not being treated like a normal person" in the hospital profoundly stunted her sense of self and her confidence in social situations, which needed to be overcome before she eventually searched for employment. Similarly, Mark described feeling stigmatized by his early psychiatric experiences, which also became a barrier for him when he returned to his job with his family's business.

> *I still felt way removed from everybody else's perspective. I felt alone and isolated, I kind of felt like I was lower than everybody else in a certain way… Also it was hard for me to…socialize with people, because I felt kind of like I had been tainted because they told me I had psychosis and that I might have schizophrenia that I might be bipolar, you know [the hospital] just kept throwing different things at me so it was hard to socialize with others because it was hard for me to feel like other people had those problems and it turns out a lot of people actually have those problems. It was just hard because I felt like I was alone, I felt like nobody really had been through what I had been through. [pause] No one would really understand, and I was also just feeling anxious so it was just hard for me to socialize even without the thoughts on top of it, you know, on top of just everyday tasks, everyday socializing with customers.*
> *– Mark, age 23*

Here, Mark expressed his general feelings of self-stigma, which originated in the psychiatric diagnostic process. Being labeled with bipolar disorder and/or schizophrenia negatively affected his self-confidence in social situations, particularly at his job. In this case, even when a young adult with a recent onset of psychosis returned to a previous employment setting, the feeling of stigma challenged his self-confidence in what were once familiar settings.

"Yeah, I Know What that's Like": Connecting with Peers to Resolve Stigma

Participants' feelings of self-stigma after their initial diagnosis were perceived as an obstacle to their employment or education goals. Several referred to this as "not feeling normal" or feeling "isolated and alone in your experience."

> *When I think about my experience about just being able to connect with other people in similar experiences and the impact that it made for me, I think it's important because it's really easy to feel isolated and alone in your experience. It's really easy to easy to become disconnected from the world around you, and to lose that connection. I think for a long time I strived to want to feel normal, and in retrospect I think it was more that I didn't want to feel abnormal. I think that being able to connect with other people that had that similar experience and that had that ability to say "yeah I know what that's like" really helped me to not feel abnormal.*
> *– Mike, age 28*

Here Mike talks about how connecting to other young adults with psychosis helped him move past feelings of abnormality and self-stigma. He further elaborated on how this connection to other young adults enrolled in his CSC program not only helped him to feel more normal, but that those who had already returned to their prior employment and education goals inspired him to do the same.

> *I think another thing that had a significant impact was being able to connect with other people in the EASA program, who were more towards the end of their EASA experience and just to see where they were at and the things they were doing really helped to inspire me as well.*
> *– Mike, age 28*

Similarly, Evan, who was in college and considering leaving his program, described how a peer who was also in college modeled how to overcome educational setbacks:

> *I needed a peer... for school, I needed a peer. A friend who had been through the same thing I was about to go through perhaps because school's hard. This internship is hard and I was thinking, "Wow, if I don't make it past this first field work, I need to choose a new path maybe." My midterm was a failing midterm and ever since that, I got really anxious and really just, "I got to pass this." I was so scared that I would fail in this tiny frame of time. But it wasn't until my friend, who also failed ... he's a year ahead of me. He reached out to me and he said, "And then I did it again and I passed with flying colors." Then I said, "Okay, so I should not be ashamed. I should not be scared. I can still do this. I don't have to go back home."*
> *– Evan, age 29*

In this case, peers were critical for modeling how to successfully navigate employment and education for those who were taking their first steps in these endeavors.

Employment Connection and Peer Mentoring through the Young Adult Leadership Council

During and after completion of the CSC program, young adults used their involvement with the YALC as a non-clinical entity to connect to vocation through formal activities and continued peer support. Although being a member of YALC was unique to this sample of young adults, it was integral to their continued engagement with vocational activities, even when they were not currently employed nor in school. As a member of YALC, participants described how they learned to speak both privately and publicly about their lived experience with psychosis and the impact that learning to reframe their experience had on their recovery journey and self-confidence. For example, Mike described how the YALC provided a space to openly discuss his experiences and gain experience with public speaking—a valuable job skill that eventually led to his employment as a CSC peer specialist.

> *I really appreciated the YALC, for a lot of good reasons, the opportunity to connect with other people, just that space that it provides for that support that it gives. And I don't think I've ever been in a room of people where I could talk as openly about feelings or experiences, not have to be so afraid of what an outsider might think, so just that general support that I received from them I really appreciated. I think that they also have set it up in a way that creates a lot of opportunities for people, I was able to be part of those opportunities, when it came to public speaking…and I think that is what helped me to create a pathway into the peer support role.*
> *– Mike, age 28*

Similarly, Meg, who also became a professional peer specialist, described how seeing another young person on the council share their story was critical for her choice to pursue training as a peer support specialist.

> *I think joining the council is really important, and like knowing that all the hard things I went through can be strengths, and*

> *you know, before I was thinking of becoming a peer specialist, I remember one of the other members of the council was…talking about going to a public speaking thing and shared her story, and I was like, what, you shared their story, people do that? It completely blew my mind (laughs), people want to hear that? This is a thing people do?"*
> *– Meg, age 28*

Furthermore, Jessica, who had described the humiliation of not being treated like a normal person in the hospital, said:

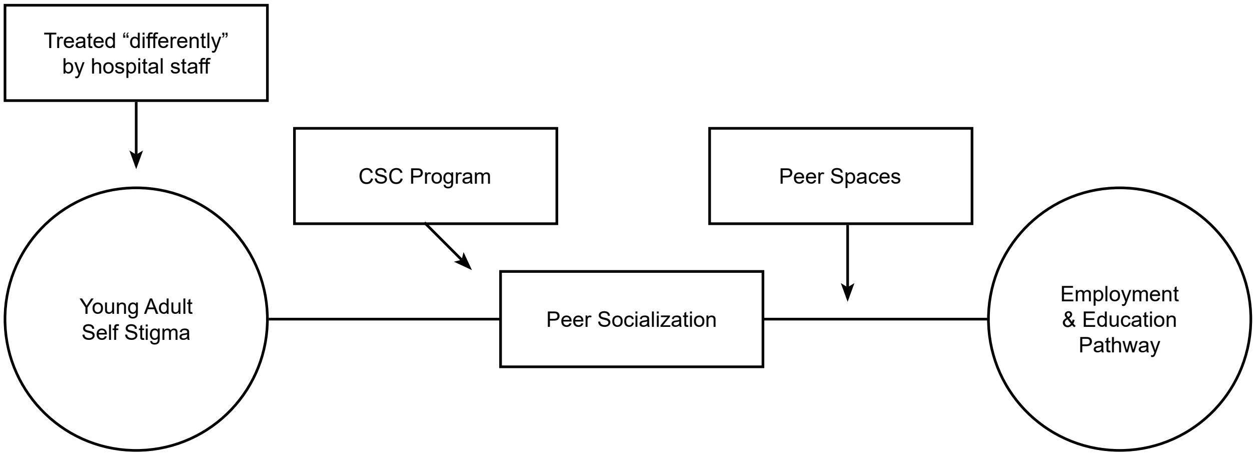
> *And I'm passionate about better mental health in general, and it's important to me that more awareness is spread. I think I'm using the council to be part of the normalizing end.*
> *– Jessica, age 25*

Jessica's words about using her council experience to be part of the "normalizing end" solidifies how this group provided connection and support for formal community advocacy for mental health, which, in Jessica's case, brought important personal closure to a once-stigmatizing experience.

Discussion

This study explored the key moments that influenced employment, education, or disability pathways among young adults with lived experience of a FEP. Findings indicated that early psychiatric hospital treatment experiences and diagnostic labeling resulted in feelings of self-stigma that stunted young adults' return to employment and education settings. The need to personally overcome "feeling abnormal" was a substantial moment in the process of returning to employment and education activities, and this personal process was facilitated when young adults encountered their own peers within CSC programs. Peers who were further along in their employment and education activities provided critical modeling, and the YALC operated as a unique space that offered ongoing peer support, mentoring, and a bridge to employment and education, as well as a formal setting for engaging in advocacy activities for mental health awareness at a community level. Figure 1 illustrates a preliminary theoretical model of these processes.

Figure 1: Resolving Self Stigma to Return to or Initiate Employment and Education Pathways



Hospitalization, Labeling, Stigma, and Normalization Processes

These findings on young adults' struggle with the initial psychiatric hospitalization and diagnosis is congruent with Labeling Theory (Ahmendani, 2011; Crocker, 1999; Goffman, 1959; Lauber et al., 2005), in which adults who are put through the process of psychiatric labeling take on the role of "patient" and the associated negative stereotypes. The young adults who described feeling they were treated as "less than" by inpatient hospital staff were on the receiving end of health professional stigma, which includes negative attitudes and social distance experienced at the hand of mental health professionals (Lauber et al., 2005).

Self-stigma refers to the individual response to the negative labeling and oft-accompanied discrimination felt by others (Crocker, 1999) and can limit participation in vocational activities. Prior studies have explored the ways that self-stigma arises from labeling and health professional stigma. Moses (2010) found that adolescents were treated differently by mental health professionals and school staff after a mental health diagnosis, thereby producing stigma. Rüsch, et al. (2014) found that self-labeling related to stigma at baseline predicted higher stigma-stress after one year, which in turn predicted worse overall well-being outcomes (e.g., quality of life and self-esteem).

Finally, previous studies have explored the ways that young adults move past the self-stigma resulting from negative hospital and/or diagnostic labeling. Gove (2004) proposed that the "in-patient phase" was characterized by moving through the labeling of "becoming a mental patient," while the "post-patient phase" was characterized by making sense of the new label when returning to normal societal roles. In a similar study on young adults with FEP and their career processes, Boychuck et al. (2018) found that pre-illness self-concept was temporarily suspended by the onset of FEP, but that a process of reengagement followed, during which individuals were able to regain some of their pre-illness self-concept. Joachim and Acorn (2000) contrast the use of stigma and normalization within chronic illness studies, with stigma referring to a negative sense of "other" bestowed upon a group with particular characteristics, while normalization is the individual's attempt to "actively adapt to changes brought forward with the condition" (p. 40). In other words, psychosis may be stigmatized by others, but individuals with psychosis may develop their own method to integrate the diagnosis and the experience into their own life.

Few studies make specific recommendations for reducing psychiatric stigma in hospital settings. Corrigan & Penn (1999) most prominently proposed a "protest, education, & contact" model of combating stigma. However, critics proposed that the dominant medical model paradigm within psychiatric education and practice will remain a challenge to reducing health professional stigma (Byrne, 2001; Read & Law, 1999). And, as hospitals and other crisis-oriented systems of care seem have less time for ongoing person-focused care (Horsefall, Cleary, & Hunt, 2010; Lauber & Sartorius, 2007), there will likely be an ongoing challenge with improving communication about psychosis and positive prognoses in these treatment settings. A potentially promising approach to mitigate health professional stigma is a clinician-training model for communicating diagnosis (Loughlin et al., 2015) but further research is needed of FEP diagnosis in hospital settings to prevent the self-stigma detailed in this study.

Peers as Mediators of Stigma

Results from this study corroborate previous research finding that socialization with peers alleviates stigma (Firman, et al., 2017; MacDonald, Sauer, Howie, & Albiston, 2005). In particular, Firman, et al. (2017) proposed a conceptual model of stigma resistance at individual, peer, and public levels that indicates the power of peer interactions and maintaining personal identity in the face of stigma. In addition, a peer-delivered anti-stigma intervention using photovoice reduced self-stigma and improved coping among adults with serious mental illness (Russinova, et al., 2014). Therefore, formation of peer relationships in the early phases of FEP and participating in peer-delivered anti-stigma interventions may improve self-confidence, self-concept and ultimately career pathways.

Non-Clinical Peer Spaces May Build Social Capital

Finally, although YALC was a unique aspect to this sample, it was significant to learn how YALC participants perceived the YALC as a critical peer support for normalizing one's experience with FEP and as a bridge to employment. It is possible that the social capital generated through participation in these peer spaces is integral to staying connected to educational and employment goals following the completion of CSC programs. While advisory boards like YALC are rare in CSC programs, with the exception of Headspace in Australia (McGorry, et al., 2007), this study's findings suggest that the creation of social, non-stigmatizing spaces that appeal to young people is critical for supporting wellness, identity and career pathways.

Implications for CSC Programs

These findings have important implications for all mental health and vocational treatment programs that young adults with FEP may encounter, but particularly for CSC and Supported Employment & Education (SEE) interventions. Broadly, CSC staff would benefit from understanding how the process of psychiatric labeling contributes to self-stigma, and how self-stigma can hold young adults back (even temporarily) from making forward strides toward employment and education. A recently funded trial will evaluate the impact of Narrative Enhancement and Cognitive Therapy (NECT) in CSC (National Institutes of Health, NCT04889911). NECT aims to decrease self-stigma through a 20-session group that uses a combination of psychoeducation, cognitive restructuring, and narrative psychotherapy elements (Dubreucq et al., 2021). CSC programs would also benefit from peer specialists with a formalized anti-stigma practice framework integrated into the team. Professional peer services have been successfully integrated into many CSC models including EASA and OnTrackNY (Bello, et al., 2017). In addition, Pyle, et al, (2018) indicate that peer specialists are uniquely positioned to address internalized stigma. Furthermore, it appears based on this study that young adults would benefit from connecting to other peers in CSC programs. However, the only empirically-established intervention that includes intentional connection between participants is Multifamily Psychoeducation (McFarlane, et al., 2010; McFarlane, Lynch, & Melton, 2012), which is not used across all CSC program models.

Finally, as this study aimed to explore key moments in employment and education pathways, these findings have implications for SEE employment intervention within CSC models. No studies to date have examined the SEE intervention itself for its impact on self-stigma. Considering that up to 40% of young adults in CSC programs do not fully-engage in employment services (Rosenheck et al., 2016) for unknown reasons, more research is needed regarding self-stigma as a barrier to engaging with SEE. It may be that routine assessment of self-identity and self-stigma may improve engagement into SEE services and employment and education attainment outcomes among young adults with FEP.

Limitations

This study has several limitations. The use of a critical case sample of young people drawn from a unique environment limits broad generalization. There was no comparison to their counterparts with FEP who were not involved in the YALC. The sample was weighted heavily toward those from more privileged families and it can be presumed that a different version of a story about the labeling process might be told by young adults from a more disadvantaged background or a sample with more black, indigenous, and other people of color (BIPOC). Finally, although the inclusion of the focus group added a strength to the data analysis, there is also the possibility that social desirability bias among participants who volunteered for the focus group could have influenced the confirmation of data.

Conclusion and Implications for Practice

This study uncovered a phenomenon that occurs within initial psychiatric experiences during a FEP that negatively impacts young adult career pathways. Young adult participants, who were an average of 5.7 years beyond the first episode of psychosis, recounted how early experiences of diagnosis and hospitalization challenged their self-concept as "normal," created feelings of self-stigma, and delayed employment and education pursuit. Connecting with peers in CSC settings contextualized the psychosis experience within their young adult identities and ultimately began the process of restoring confidence in themselves. Participation in the YALC provided a transitional space with exposure to employment and education and vocational activities as well as continued peer support. This study indicates that CSC models should consider the ways that early psychiatric labeling can construct self-stigma, and how this stunts the self-confidence needed to pursue vocational goals. This could be addressed by encouraging peer connections within CSC programs and though improving vocational assessment of one's self-concept, identity, and feelings of stigma as it relates to employment and educational goals. CSC providers should consider strategic development of peer connections (e.g., social activities that promote peer-to-peer connections and informal mentoring) and young adult advisory boards to mitigate self-stigma and promote career success among young people with FEP.

References

Agerbo, E., Byrne, M., Eaton, W., & Mortensen, P. (2004). Marital and labor market status in the long run in schizophrenia. *Archives of General Psychiatry, 61*(1), 28–33.

Ahmedani, B. K. (2011). Mental health stigma: Society, individuals, and the profession. *Journal of Social Work Values and Ethics, 8*(2), 4–1.

Baron, R., Draine, J., & Salzer, M. (2013). "I'm not sure that I can figure out how to do that": Pursuit of work among people with mental illnesses leaving jail. *American Journal of Psychiatric Rehabilitation, 16*(2), 115–135.

Baron, R., & Salzer, M. S. (2002). Accounting for unemployment among people with mental illness. *Behavioral Sciences & the Law, 20*(6), 585–599.

Bello, I., Lee, R., Malinovsky, I., Watkins, L., Nossel, I., Smith, T., ... & Dixon, L. B. (2017). OnTrackNY: The development of a coordinated specialty care program for individuals experiencing early psychosis. *Psychiatric Services, 68*(4), 318–320.

Biagianti, B., Quraishi, S. H., & Schlosser, D.A. (2018). Potential benefits of incorporating peer-to-peer interactions into digital interventions for psychotic disorders: A systematic review. *Psychiatric Services, 69*(4), 377–388.

Birchwood, M., & Fiorillo, A. (2000). The critical period for early intervention. *Psychiatric Rehabilitation Skills, 4*(2), 182–198.

Blajeski, S. (2019). *"On the cusp": Pathways to employment, education, and disability in first-episode psychosis (FEP).* Doctoral Dissertation.

Blajeski, S. (2020). Family support, forming careers, and breaking the disability mindset: Implications for addressing structural barriers to employment pathways in coordinated specialty care for first-episode psychosis. *Social Work in Mental Health, 18*(5), 461–481.

Boychuck, C., Lysaght, R., & Stuart, R. (2018). Career decision-making processes of young adults with first-episode psychosis. *Qualitative Health Research, 28*(6), 1016–1031.

Byrne, P. (2001). Psychiatric stigma. T*he British Journal of Psychiatry, 178*(3), 281–284.

Corrigan, P. & Penn, D. L. (1999) Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist, 54*, 765–776.

Crabtree, B. F., & Miller, W. L. (1992). A template approach to text analysis: developing and using codebooks. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research: Multiple strategies* (pp. 93–109). Thousand Oaks, CA: Sage.

Crocker, J. (1999). Social stigma and self-esteem: Situational construction of self-worth. *Journal of Experimental Social Psychology, 35*(1), 89–107.

Crowther, R., Marshall, M., Bond, G. R., & Huxley, P. (2001). Vocational rehabilitation for people with severe mental illness. *Cochrane Database of Systematic Reviews, 2.*

Denzin, N. K. (2017). Critical qualitative inquiry. *Qualitative Inquiry, 23*(1), 8–16.

Drake, R. E., Becker, D. R., Clark, R. E., & Mueser, K. T. (1999). Research on the individual placement and support model of supported employment. *Psychiatric quarterly, 70*(4), 289–301.

Dubreucq, J., Faraldo, M., Abbes, M., Ycart, B., Richard-Lepouriel, H., Favre, S., ... & Franck, N. (2021). Narrative enhancement and cognitive therapy (NECT) to improve social functioning in people with serious mental illness: Study protocol for a stepped-wedge cluster randomized controlled trial. *Trials, 22*(1), 1–9.

Early Assessment & Support Alliance (EASA). (2018). *The young adult leadership council*. Retrieved from http://easacommunity.org/the-young-adult-leadership-council.php

Estroff, S. E., Zimmer, C, Lachicotte, W, Benoit, J, & Donald, P. (1997) "No other way to go": Pathways to disability income application among persons with severe, persistent mental illness. In Bonnie, R., & Monahan, J. (Eds.) *Mental disorder, work disability, and the law*. Chicago, IL: University of Chicago Press.

Firmin, R. L., Luther, L., Lysaker, P. H., Minor, K. S., McGrew, J. H., Cornwell, M. N., & Salyers, M. P. (2017). Stigma resistance at the personal, peer, and public levels: A new conceptual model. *Stigma and Health, 2*(3), 182.

Funk, M., Drew, N., & Knapp, M. (2012). Mental health, poverty and development. *Journal of Public Mental Health, 11*(4), 166–185.

Garrow, E. E. & Hasenfeld, Y. (2015). The epistemological challenges of social work intervention research. *Research on Social Work Practice, 27*(4), 494–502.

Goffman, E. (1959). The moral career of a mental patient. *Psychiatry, 22*(2), 123–142.

Gove, W. R. (2004). The career of the mentally ill: An integration of psychiatric, labeling/social construction, and lay perspectives. *Journal of Health and Social Behavior, 45*, 357–375.

Heinssen, R. K., Goldstein, A. B., & Azrin, S. (2014, April). *Evidence-based treatments for first episode psychosis: Components of coordinated specialty care: RAISE*. National Institute of Mental Health. Retrieved from https://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf

Horsfall, J., Cleary, M., & Hunt, G. E. (2010). Stigma in mental health: Clients and professionals. *Issues in mental health nursing, 31*(7), 450–455.

Joachim, G., & Acorn, S. (2000). Living with chronic illness: The interface of stigma and normalization. *Canadian Journal of Nursing Research, 32*(3), 37–48.

Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., Addington, J., Brunette, M. F., Correll, C. U., Estroff, S. E., Marcy, P., Robinson, J., Meyer-Kalos, P. S., Gottlieb, J. D., Glynn, S. M., Lynde, D. W., Pipes, R., Kurian, B. T., Miller, A. L., . . . Heinssen, R. K. (2016). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE Early Treatment Program. *American Journal of Psychiatry, 173*(4), 362–372.

Killackey, E., & Allott, K. (2013). Utilising Individual Placement and Support to address unemployment and low education rates among individuals with psychotic disorders. *Australian & New Zealand Journal of Psychiatry, 47*(6), 521–523.

Lauber, C., Nordt, C., & Rössler, W. (2005). Recommendations of mental health professionals and the general population on how to treat mental disorders. *Social Psychiatry and Psychiatric Epidemiology, 40*(10), 835–843.

Lauber, C., & Sartorius, N. (2007). At issue: Anti-stigma-endeavours. *International Review of Psychiatry, 19*(2), 103–106.

Loughland, C., Kelly, B., Ditton-Phare, P.,Sandhu, H., Vamos, M., Outram, S., . . . ComPsych, I. (2015). Improving clinician competency in communication about schizophrenia: A pilot educational program for psychiatry trainees. *Academic Psychiatry, 39*(2), 160–164.

Lucksted, A., Essock, S. M., Stevenson, J., Mendon, S. J., Nossel, I. R., Goldman, H. H., Goldstein, A. B., & Dixon, L. B. (2015). Client views of engagement in the RAISE Connection Program for early psychosis recovery. *Psychiatric Services, 66*(7), 699–704.

Lund, C. (2012). Poverty and mental health: A review of practice and policies. *Neuropsychiatry, 2*(3), 213–219.

MacDonald, E., Sauer, K., Howie, L., & Albiston, D. (2005). What happens to social relationships in early psychosis? A phenomenological study of young people's experiences. *Journal of Mental Health, 14*(2), 129–143.

McFarlane, W. R., Cook, W. L., Downing, D., Verdi, M. B., Woodberry, K. A., & Ruff, A. (2010). Portland identification and early referral: A community-based system for identifying and treating youths at high risk of psychosis. *Psychiatric Services, 61*(5), 512–515.

McFarlane, R.W., Lynch, S., & Melton, R. (2012). Family psychoeducation in clinical high risk and first-episode psychosis. *Adolescent Psychiatry, 2*(2), 182–194.

McGorry, P. D., Tanti, C., Stokes, R., Hickie, I. B., Carnell, K., Littlefield, L. K., & Moran, J. (2007). Headspace: Australia's National Youth Mental Health Foundation—where young minds come first. *Medical Journal of Australia, 187*(S7), S68–S70.

Melton, R. P., Roush S. N., Sale T. G., Wolf, R. M., Usher, C. T., Rodriquez, C. L., & McGorry, P. D. (2013). Early intervention and prevention of long-term disability in youth and adults: The EASA model. In K. Yeager, D. Cutler, D. Svendsen, & G. Sills (Eds.), *Modern community mental health: An interdisciplinary approach* (pp. 256–275). Oxford University Press.

Moses, T. (2010). Being treated differently: Stigma experiences with family, peers, and school staff among adolescents with mental health disorders. *Social science & medicine, 70*(7), 985–993.

Mueser, K. T., & McGurk, S. R. (2004) Schizophrenia. T*he Lancet, 363*, 2063–2072.

National Institutes of Health. (2021). *Pilot RCT of Self-stigma Treatment for First Episode Psychosis*. NCT04889911

Nossel, I., Wall, M. M., Scodes, J., Marino, L. A., Zilkha, S., Bello, I., ... & Dixon, L. (2018). Results of a coordinated specialty care program for early psychosis and predictors of outcomes. *Psychiatric Services, 69*(8), 863–870.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods, 16*(1).

Patton, M. (1990). *Qualitative evaluation and research methods* (2nd ed.). SAGE Publications.

Pyle, M., Pilling, S., Machin, K., Allende-Cullen, G., & Morrison, A.P. (2018) Peer support for internalised stigma experienced by people with psychosis: Rationale and recommendations, *Psychosis, 10*(2), 146–152.

Ramsay, C. E., Stewart, T., & Compton, M. T. (2012). Unemployment among patients with newly diagnosed first-episode psychosis: Prevalence and clinical correlates in a US sample. *Social Psychiatry and Psychiatric Epidemiology, 47*(5), 797–803.

Read, J. & Law, A. (1999) The relationship between causal beliefs and contact with users of mental health services to attitudes to the 'mentally ill'. *International Journal of Social Psychiatry, 45*, 216–229.

Rosenheck, R., Mueser, K, T., Sint, K., Lin, H., Lynde, D. W., Glynn, S. M.,…Kane J. M. (2016). Supported employment and education in comprehensive, integrated care for first episode psychosis: Effects on work, school, and disability income. *Schizophrenia Research, 182*, 120–128.

Rowland, T., & Marwaha, S. (2018). Epidemiology and risk factors for bipolar disorder. *Therapeutic Advances in Psychopharmacology, 8*(9), 251–269.

Rüsch, N., Müller, M., Heekeren, K., Theodoridou, A., Metzler, S., Dvorsky, D., ... & Rössler, W. (2014). Longitudinal course of self-labeling, stigma stress and well-being among young people at risk of psychosis. *Schizophrenia Research, 158*(1–3), 82-84.

Russinova, Z., Rogers, E. S., Gagne, C., Bloch, P., Drake, K. M., & Mueser, K. T. (2014). A randomized controlled trial of a peer-run antistigma photovoice intervention. *Psychiatric Services, 65*(2), 242–246.

Shinn, A. K., Cawkwell, P. B., Bolton, K., Healy, B. C., Karmacharya, R., Yip, A. G., Öngür, D., & Pinder-Amaker, S. (2020). Return to college after a first episode of psychosis. *Schizophrenia Bulletin Open, 1*(1), sgaa041.

Sylvestre, J., Notten, G., Kerman, N., Polillo, A., & Czechowki, K. (2018). Poverty and serious mental illness: Toward action on a seemingly intractable problem. *American Journal of Community Psychology, 61*(1–2), 153–165.

Williams, C. C., & Collins, A. A. (2002). The social construction of disability in schizophrenia. *Qualitative Health Research, 12*(3), 297–309.

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