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A Qualitative Study of Career Exploration among Young Adult Men with Psychosis and Co-occurring Substance Use Disorder

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Abstract

Objective—This article explores the meaning and importance of career exploration and career development in the context of integrated treatment for young adults with early psychosis and substance use disorders (i.e., co-occurring disorders).

Methods—Twelve young adult men (aged 18 to 35 years) with co-occurring disorders recruited from an integrated treatment center completed a series of three semi-structured in-depth qualitative interviews. Data were transcribed verbatim and analyzed using thematic analysis. Purposive sampling ensured participants represented a range of substance abuse treatment stages.

Results—Participants had a mean age of 26 ($SD = 3$) and identified as White. Two-thirds of participants ($n = 8$, 67%) were diagnosed with schizophrenia-spectrum disorders, three (25%) with bipolar disorder, and one (8%) with major depression; four (33%) also had a co-occurring anxiety disorder. The most common substance use disorders involved cannabis ($n = 8$, 67%), cocaine ($n = 5$, 42%), and alcohol ($n = 5$, 42%). These young adult men with co-occurring disorders described past jobs that did not align with future goals as frustrating and disempowering, rather than confidence building. Most young adult participants began actively developing their careers in treatment through future-oriented work or school placements. They pursued ambitious career goals despite sporadic employment and education histories. Treatment engagement and satisfaction appeared to be linked with career advancement prospects.

Conclusions—Integrating career planning into psychosocial treatment is a critical task for providers who serve young adults with co-occurring disorders. Whether integrating career planning within early intervention treatment planning will improve clinical, functional, or economic outcomes is a promising area of inquiry for rehabilitation researchers and clinicians.

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NOTE

The individuals discussed in this paper are actual clients. Names are pseudonyms and key details have been altered to protect their identities (e.g., place of school or work).

DISCLOSURES

The authors report no financial relationships with commercial interests with regard to this study.

Keywords

qualitative; psychosis; co-occurring disorders; employment; education

Career development is the process by which people identify career interests, make career choices, or pursue advancement of a desired vocational identity. In young adulthood, career development unifies key age-related tasks—finishing school, pursuing employment, and developing a sense of personal identity. Researchers have developed intensive outpatient psychosocial rehabilitation programs for young adults with psychotic symptoms (i.e., early psychosis programs) to support young people in achieving these milestones (Birchwood, Todd, & Jackson, 1998; McGorry, 2004). Accumulating evidence suggests that early psychosis programs improve short-term employment rates among these young people, especially when programs include employment-specific supports (Bond, Drake, & Luciano, 2014), but the outcomes and experience of long-term career development among young adults with psychosis who receive treatment remain largely unexplored. We do not yet know what proportion of treatment participants who achieve employment remain employed over time; what supports are necessary to sustain employment; or whether career development leads to significant psychological improvement, functional gains in other areas, or reduced disability enrollment.

A leading theory of career development, Social Cognitive Career Theory, posits that career interests, choices, and behaviors are informed by weighing the balance of barriers and supports, which inform anticipated career outcomes and perceived obstacles (Lent, Brown, & Hackett, 2000). It highlights the malleability of career development based on real and perceived barriers and facilitators. Research has identified intrapersonal (e.g., task competency and coping efficacy), proximal environmental (e.g., parental financial support and expectations), and societal (e.g., job availability and discrimination) factors that are associated with career exploration and development (Lent, et al., 2000). Illness-related experiences among young adults may alter the barriers and supports relevant to career development in treatment. Young adults with psychosis perceive many barriers to employment—low self-confidence, stigma, symptom management, public benefits, goal ambiguity, and family members' low expectations—yet they often remain motivated to seek employment in pursuit of financial stability, social inclusion, self-esteem, and a sense of normalcy (Boydell, Stasiulis, Volpe, & Gladstone, 2010; Rinaldi et al., 2010). Negative school and work experiences during pre-morbid/prodromal illness phases might diminish anticipated career outcomes and magnify perceived career barriers (Gioia, 2005). To inform the development of vocational services in early psychosis programs and affect lifelong workforce involvement, the field needs to learn more about how young adults with psychosis conceptualize the stages of career development through the telling of personal narratives.

The research presented here used in-depth interviews to extensively explore past and current experiences with work, school, and volunteer opportunities among twelve young adult men diagnosed with psychosis and substance use disorder participating in integrated treatment for co-occurring substance use and mental disorders.¹

METHODS

We recruited participants from a private, non-profit clinic. As one of the few programs in the United States that focuses on the provision of integrated treatment for co-occurring disorders, the clinic provided an uncommon empirical opportunity to learn about the subjective experience of career development in the context of appropriate rehabilitative supports (McGovern, Lambert-Harris, Gotham, Claus, & Xie, 2014). Services included education, case/care management, medication management, assistance with daily living tasks, assistance with housing, money management, cognitive behavioral therapy, substance use counseling, family psychoeducation, and a variety of related evidence-based interventions and other specialized counseling (Woods & Drake, 2011). The clinic served mostly younger individuals between 18 and 35 with limited experience living independently and multiple failed treatment attempts in nonintegrated settings. Although treatment scholarships were provided to some patients, availability was limited; therefore, participants often came from professional, resource-rich family backgrounds. The interviewer visited the site monthly for one year prior to conducting interviews, totalling over 100 hours of observation and shadowing. Immersion into the clinical environment improved the interviewer's capacity to understand and appreciate the 'local language' of the program during in-depth interviews, which included peer nicknames and clinical jargon.

Study Sample

The following criteria determined study eligibility: (1) diagnosed with co-occurring psychotic illness and substance use disorder, (2) currently receiving residential or outpatient services at the integrated mental health and substance use treatment center, (3) between 18 and 35 years of age, and (4) able to provide informed consent. The clinic provided single-sex (male) housing for residential patients in keeping with best practices for substance use care. The site did not provide complementary women's residential housing at the time of recruitment.

Measures and Operational Definitions

Content covered by the qualitative interview was informed by previous qualitative literature identifying life domains central to the lived experience of co-occurring substance use and mental illness (Hipolito, Carpenter-Song, & Whitley, 2011; Whitley & Drake, 2010), results from a pilot project, and informal discussions with consumers. Domains included past and current mental health and substance use status and treatment, but emphasized functional domains involving daily routines; housing; relationships with family, peers, and clinicians; work, school, volunteering, and public benefits; spirituality; self-help; and past accomplishments and future goals. Early interview questions explored generally nonsensitive information (e.g., daily routine), and later interviews explored more sensitive information (e.g., drug use behavior) to capitalize on the trust and rapport-building that occurs over repeated interaction. Due to the depth and breadth of the interview questions, the lead investigator conducted the interview over a series of three encounters for each

¹Over half of people with early stage psychotic illness have a substance use disorder related to misuse of cannabis, alcohol, or other drugs (Farrelly et al., 2007; Graham et al., 2001; Kovasznay et al., 1997; Wade et al., 2006; Wade, Harrigan, Edwards, & al, 2005).

participant. Data on age, race, mental health diagnosis, and substance use diagnosis were collected via record review. Diagnosis was based on a comprehensive screening assessment conducted by psychiatrists and psychiatric nurses upon admission to the treatment clinic.

Sample Recruitment and Data Collection Procedures

Prior to recruitment, all clinicians at the study site were informed of the research study, including the study's purpose, methods and procedures, and risks. Clinical staff provided a brief description of the research to all eligible clients ($N = 15$) and referred interested participants to the lead investigator. Following staff referral, the lead investigator described the study, invited questions, emphasized that participation or non-participation had no effect on clinical services, and conducted written informed consent procedures. The final sample size for the study included 12 young adult men with co-occurring disorders at varying stages of treatment. Reasons for nonparticipation included lack of interest in research participation ($n = 2$) and plans to leave treatment within less than one week ($n = 1$). Participants received a \$20 gift card for each interview.

The investigator offered a variety of possible interview settings within the community from which each participant chose to conduct the interview (coffee shops, in/outpatient offices). Participants often preferred a private room in a secluded area of the office with white noise machines for convenience. The three interview sessions occurred over the course of four weeks following enrollment. With participant permission, interviews were audio-recorded. The study description was reiterated at each interview to remind participants of the voluntary nature of their participation. Program administrators facilitated record review following qualitative data collection. The Dartmouth College Committee for the Protection of Human Subjects approved and monitored the study. A Certificate of Confidentiality was also issued by a scientific review officer from the National Institute on Drug Abuse.

Data Analysis

The lead investigator analyzed verbatim transcriptions of the audio-recorded interviews using Atlas.ti (Atlas.ti 2.0, 2002), a qualitative coding software program. Portions of text were descriptively labeled (e.g., housing, education, treatment seeking). Researchers then proceeded to 'focused coding', which involves detailed investigation of prominent themes identified in the early descriptive process (Emerson, Fretz, & Shaw, 1995). Throughout the process, the lead investigator documented concepts, themes, and issues suggested by the data through memos. A second researcher checked qualitative coding for face validity and discussed disagreements with the lead investigator until reaching consensus. Following initial coding and analysis of transcripts, the lead investigator developed a case summary for each participant. Across-case analyses of themes compared individuals. Interpretation of meaning was constrained to themes that recurred and unified the narratives. Thematic findings were presented to a consumer-researcher advisory panel to check agreement between thematic analysis and participant transcripts, a protection against selectivity in data use. Researchers chose representative quotations from the interviews to illustrate themes. We also report demographic and clinical characteristics summarized for the overall sample to complement the qualitative data. Results are presented in keeping with published standards for qualitative research (Mays & Pope, 1995). Certain minor details, such as the

place of work or school, have been changed to mask participants' identity. The names in this article are pseudonyms.

RESULTS

Participants were male, identified as White, and young (mean age = 26 years, $SD = 3$, range 22 to 32 years). Eight participants in the study (67%) met clinical diagnostic criteria for schizophrenia-spectrum disorder, three (25%) met criteria for bipolar disorder, and one (8%) met the criteria for major depressive disorder. Four participants in the study (33%) had a co-occurring anxiety disorder (social phobia, obsessive compulsive, or post-traumatic stress disorder). Participants were diagnosed with abuse or dependence of cannabis ($n = 8$, 67%), cocaine ($n = 5$, 42%), alcohol ($n = 5$, 42%), poly-substances ($n = 3$, 25%), amphetamines ($n = 1$, 8%), and opioids ($n = 1$, 8%) at the time of admission to residential treatment. Seven participants (58%) were in total substance use disorder remission at the time of interview, two (17%) continued to abuse more than one substance, one (8%) continued abusing alcohol and was dependent on cannabis, one (8%) continued abusing opioids, and one (8%) remained dependent on more than one substance. Most participants were raised in professional families with middle- to upper-level incomes. Often participants' immediate relatives—siblings and parents—were accomplished students and professionals. Low socioeconomic diversity is typical in private sector mental health services.

The participants usually described life before and during illness onset as chaotic, commonly involving academic discontinuation, criminal justice involvement, multiple failed treatment experiences, social dysfunction (isolation and/or abuse), periodic homelessness, unemployment, repeated hospitalization, low self-esteem, depression, and suicidality. Several participants experienced repeated relapses, which demoralized their sense of self-efficacy and reduced parental expectations.

School and Work History Prior to Integrated Services

One of the twelve participants had completed post-secondary schooling. Participants expressed that they had often struggled academically, and most had transferred from one academic institution to another. One young man summarized his experience transferring in and out of three different schools: "I'm very frustrated by the education system and just how badly I've done with it." Many participants noted a lack of support during college years, and none mentioned a useful source of academic help outside of the family.

Service-level jobs dominated the work history narratives. Participants explained that they usually pursued these low-skill, low-wage jobs at the recommendation of family members. The experiences were not fulfilling. Josh's story provides an emblematic example:

Josh "hasn't really worked much." He lived at home for several years after college, and was unemployed for most of that time. He worked at a hardware store two days a week, but quit after a month. The position required little responsibility and no accountability: "It was just, like, I'd come in and work for a little while and leave whenever I wanted. I made my own hours and stuff like that." Yet he did not enjoy the freedom: "Without the structure I just wasn't able to stay healthy I guess."

Ambitious Career Goals

The participants explored and refined their career choices based on their personal interests during the course of treatment. Ten of the twelve participants set ambitious career goals, spanning a wide range of interests. For example, Adam hoped to pursue an advanced degree and join the family's business as an executive; Frank pursued a career as a health laboratory technician; and Evan set his sights on becoming an assistant manager in a national business franchise. Pete wanted to own his own retail store. He also considered military enlistment and spoke with recruiters. Alexander weighed his options:

...I've thought about teaching ESL, getting certified to teach English either in the U.S. or abroad. With the health stuff I've thought about possibly going to become a massage therapist and from there, maybe a physical therapist. And I know that I like physical labor and being outside. I've done some farming in the past, so that's another thing that I've thought about doing again. So those are some of the things I've been thinking about as far as work.

Although career-related goals were common among participants, two participants put career planning on hold, including Ricky, who revolved in and out of treatment for nearly a decade. Ricky's primary goal was to get his own apartment: "I really want my own place. It's been my goal for a while but it didn't seem feasible." "I want to have a job but I'm going to start doing the volunteer stuff first."

Translating Career Goals to Action

In outpatient treatment, the men translated their broad career aspirations into more specific, actionable steps. For example, Adam aimed to complete his university degree: "I'm almost done at [university]. I already signed up for the fall. Then I have the spring and then I have my undergrad finished."

The men achieved concrete successes as they pursued their long-term career entry goals. Adam neared college graduation, and Frank earned academic accolades. They derived a great deal of satisfaction from these experiences: "It's made me feel more confident, I guess. Made me feel grateful. I think it's helped me get smarter a little bit and try working out my brain and stuff." External support magnified the impact that these incremental successes had on their self-perception: "...When my parents or my family or whoever is proud of me it does keep me going. It helps out. It's, like, a breath of fresh air for a second. You're, like, oh, I am doing the right thing."

Career Development and Treatment Engagement

The young adult men attributed shifts in health, functioning, and psychological well-being to integrated treatment for psychosis and substance use. They appreciated career support: "She's a friend. She's a care manager. I don't know, she just supports me with where I want to go and what my goals are." Contrastingly, four of the twelve men felt they had exhausted the future-oriented work and school possibilities in the local area and planned to disengage from services. For example, Jared aspired to have a career in his family's carpentry business. Since this would require relocation back to his hometown, he started to wind down his involvement in Alcoholics Anonymous and stopped trying to form friendships. Although

Jared agrees that treatment has been helpful, “I went from 1% well to 99% better,” he wanted to disengage from treatment. “Enough’s enough. I want to act my own age. I’m my own person. Period.”

DISCUSSION

The interviews demonstrate that some young adults with co-occurring disorders desire and pursue ambitious career goals despite sporadic employment and education histories. Activities that do not align with career goals are frustrating and disempowering, rather than confidence or skill building. The results are consistent with general career theorists, who stress the importance of contextual influences on career development attitudes and behavior (Lent, Brown, & Hackett, 1994; Lent, et al., 2000). The findings further develop a conceptual framework relating pre- and post-illness-onset work experiences (Gioia, 2005) by illustrating that the rehabilitative orientation of services themselves bear strong contextual influence on career interests, choices, and behaviors. Rather than comparing pre-treatment versus post-treatment, the young adults juxtaposed their career development before and after entering integrated psychosocial treatment, as illustrated in the presentation of the narratives. Many contextual changes coincided with integrated dual disorder treatment entry that might have facilitated improvement. Some factors were relatively overt, such as receiving integrated psychosocial services for mental health and substance use, developing a newly positive sense of self, and achieving substance use reduction; other factors were subtler, such as comparative norms and learned self-efficacy through in vivo experience.

A descriptive review of qualitative studies in first episode psychosis (Boydell, et al., 2010) noted that “qualitative explorations of beliefs and understandings are needed to determine how interventions are experienced and implemented in clinical practice” (p. 8). And that “A central *raison d’être* for engaging in qualitative research is to enhance our understanding and appreciation of phenomena – an understanding that depends on the context-specific collection and interpretation of the meanings people attach to their behaviour, how they interpret situations and their perspectives on particular issues” (p. 8). Thus, the findings presented and discussed here must be considered in the context from which they were gathered. Future research using other appropriate means of testing can draw on these findings to understand if and how they generalize to other contexts, and whether they can inform strategies that improve care for psychosis in meaningful ways.

This study of work, school, and career development revealed phenomena of interest for future investigation and implications for treatment. First, whether an activity is future-oriented or not appears to substantially impact how clients perceive productive roles. Before treatment and at other treatment settings, participants had experienced many low-skill jobs, volunteer positions, and some had tried non-credit awarding educational experiences. Placements with no advancement potential were often frustrating and lowered participants’ confidence, rather than increasing self-esteem and self-efficacy. Presumably clinicians and family members recommend opportunities with low responsibility, time commitment, social engagement and cognitive requirements with the opposite intention. The psychological impact of disparities between career ideals and career realities may have been particularly strong in the current sample pre-treatment, given the career accomplishments of family

members and peers. Early intervention services should consider prioritizing career-oriented opportunities as mechanisms to promote feelings of self-efficacy and optimism regarding career development potential. Examples include finishing school, job training for career-oriented goals, gaining relevant early-career work experience, and starting a business.

Second, attending and responding to young adult clients' career goals and development may also be a useful treatment engagement strategy. People with co-occurring disorders are at particularly high risk of disengagement from early psychosis treatment programs (Doyle et al., 2014). Career exploration appears to have facilitated treatment satisfaction, except in cases where future-oriented job opportunities were geographically distant from the treatment center. Aligning work activities with stage of readiness for career development will likely improve treatment engagement.

Third, career motivations may explain why young adults with psychosis often identify education as a treatment outcome priority (Nuechterlein et al., 2008; Ramsay et al., 2011). Although efforts to support the process of finding and supporting educational placements began in the 1990s (Unger, 1998), supported education has not yet crystalized into one evidence-based model (Mueser & Cook, 2012). The absence of a systematic strategy to integrate support for education or training goals with vocational rehabilitation services presents a practical conundrum for young adults with psychosis who seek career advancement opportunities and an important potential target for intervention developers.

Study Limitations

Based on a recent review of qualitative studies among people with early psychosis (Boydell, et al., 2010), the current study fills a critical gap in the literature by addressing the career-orientation of young adults with co-occurring disorders engaged in treatment. Still, several limitations to the study warrant consideration. These data are cross-sectional, precluding causal interpretation. Further, the study sample did not include women, people not in integrated treatment for mental health and substance use disorders, older adults, or people of lower socioeconomic status. Although the study was not designed to examine these populations, an obvious next step in this line of research is to explore similar patterns longitudinally, among women, among varying age groups, and among samples in a variety of treatment and non-treatment settings with more diverse socio-economic backgrounds. We did not attempt to determine historical truth of accounts collected. Selective reconstruction and omission, intentional or otherwise, were possible, but do not devalue this study of oral narratives.

Conclusion

Understanding the process of career development and health maintenance among young adults with co-occurring disorders is needed to provide a context for efforts to prevent extended periods of disability (Krupa et al., 2012). This qualitative study has shown that these young adults can envision a meaningful future career path for themselves, despite sporadic employment and education histories. Participants especially valued treatment when it facilitated preparation and action towards career development by supporting future-oriented work and school opportunities. Whether integrating career planning within

treatment planning will improve clinical, functional, or economic outcomes is a critical next area of inquiry for rehabilitation researchers and the clinicians who provide services to young adults with early psychosis.

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