ARTICLE

A Place to Be: The Role of Clubhouses in Facilitating Social Support

▼

Marsha Carolan and Esther Onaga

Michigan State University

Francesca Pernice-Duca

Wayne State University

Tiffeny Jimenez

Michigan State University

Objective: Intentional recovery communities, such as clubhouse programs, aim to foster social connections among individuals at risk for isolation as a result of living with a serious mental illness to engage and become active participants in the community. The objective of the study was to gather information on the nature of clubhouse support as it pertains to social network support and social relationships. *Methods:* The personal story/narrative approach was utilized and involved a naturalistic inquiry approach that allowed stories of clubhouse experiences to come forth with little interference or interjection as possible. *Results:* Personal narratives revealed that staff, members and the overall clubhouse structure emerged as the center of social interaction and comfort for participants and a central sustaining means of social support. *Conclusions and Implications for Practice:* It appears that the clubhouse provides an intentional environment that creates a sense of community and a place to belong. The clubhouse as a place to be where one can meet individuals in like situations has been identified as very helpful in achieving recovery by providing the opportunity to rebuild one's shattered social network and offering contact with others in similar contexts.

Keywords: clubhouse programs, recovery, qualitative research, psychosocial rehabilitation

Introduction

Individuals living with a serious mental illness are often isolated, stigmatized, and marginalized members of their communities as result of their illness (Brugha, 1995). Inadequate social support is associated with increased risk for psychiatric disorders (Hawkely & Cacioppo, 2010) and poor physical and social functioning (Howard, Leese, & Thornicroft, 2000). The social disability accompanying some major mental illnesses can become a primary source of stress that can limit coping skills and negatively influence quality of life (Borge, Martinsen, Ruud, Watne, & Friis, 1999). A social support system may become a critical component to

well-being, coping, and mental health recovery (Corrigan & Phelan, 2004; Hendryx, Green, & Perrin, 2009; Kawachi, Kennedy, & Glass, 1999). The social relationships and social functioning that emerge from social support systems are correlated with an individual's performance at work, home, and other social contexts (Evert, Harvey, Trauer, & Herrman, 2003).

The National Consensus on Recovery from Mental Illness emphasizes the role of social support networks and interpersonal relationships as a core function of the recovery process (SAMHSA, 2006), thus providing the impetus for mental health programs to improve and sustain such social supports (Kilbourne, McCarthy, Post, Welsh & Blow, 2007). Clubhouses by definition are intentional recovery communities that foster interpersonal connections and support, playing a vital role in psychiatric rehabilitation (Bellack & Mueser, 1993) and recovery (Pernice-Duca & Onaga, 2009). Clubhouses operate within an egalitarian social and decision-making structure upholding the firm belief that work and work-mediated relationships are restorative and offer a solid foundation for growth and important individual achievement (Beard, Propst, & Malamud, 1982).

Clubhouses emphasize interpersonal collaboration, social networking and social support by providing ongoing peer support that may substitute for more naturally occurring kin support or friendships. This intentional community has been described as embodying a family-like environment that supports recovery through the importance of meaningful clubhouse work and social relationships (Herman, Onaga, Pernice-Duca, Oh, & Ferguson, 2005). In a large study involving clubhouse members, Pernice-Duca (2008) examined the scope of social relationships and dis-

covered that staff and fellow members comprise a substantial portion of the social support system. The support networks engendered in peer-oriented organizations translate into "networks of caring" to support the recovery process (Hardiman, 2004).

To further understand the nature of peer-oriented, mutual support organizations, Rappaport (1993; 1995; 2000) has called for an emphasis on narrative studies and interpretation and the use of personal stories. These approaches are an increasingly preferred method in studies involving consumers (Staeheli, Stayner, & Davidson, 2004; Whitely & McKenzie, 2005). Studies involving clubhouses have relied on qualitative approaches to give voice to consumers and their experiences within the rehabilitation environment (Norman, 2006; Waegemakers Schiff, Coleman, & Miner, 2008). The role of personal stories can illuminate how people understand community (Rappaport, 1993), and can be an especially powerful avenue to understanding the lived experiences of the consumer. Personal stories are also congruent with the values of consumer empowerment, allowing the individual to gain coherence, control, and power in the *telling* of their story.

Objectives

The primary objective of these studies was to examine social support and interpersonal relationships within the clubhouse setting. The main objective was to gather personal stories of clubhouse members' social support experiences within the clubhouse. The conceptual framework guiding this study was based on a trans-ecological model (Bronfenbrenner, 1986; Moos, 2003) emphasizing that individuals develop in proximal relationships with persons and aspects of their environments. It was contended that peer re-

lations and clubhouse staff are central in the clubhouse environment. Therefore the impact of the clubhouse and the day-to-day interactions with people in proximity to this environment were explored.

Methods

Setting

A clubhouse in a rural community of a mid-western state was selected to participate in this study. The clubhouse was selected for its commitment to following benchmarks established by the International Center for Clubhouse Development (ICCD) and certification status.

Participants

Criterion-based targeted sampling was employed (Cresswell, 2007) and included the following: (1) active memberships (i.e., members were involved with the clubhouse for at least six months and attended at least three times per week, within the last six months) and (2) members had sufficient cognitive ability and expression (i.e., ability to comprehend the consent process and coherently respond to interview questions to participate in a 60-90 minute interview). Members (*n* = 20) were recruited through announcements at clubhouse house meetings and by word of mouth. The clubhouse director assisted in identification of members who met the criteria. Gender distribution (10 males and 10 females) was deliberate but ethnic and racial reference group distribution was representative of the specific clubhouse. Participants were between 34 and 60 years of age (*M* = 44 years) and mostly reported a diagnosis of schizophrenia (*n* = 12) and affective disorders (*n* = 5). Many participants identified as White (*n* = 17), one identified as African American, one as Latino, and one as Native American. Most members identi-

fied as never married (n = 9), divorced (n = 7), and living independently (n = 16). Thirteen members were high school graduates, four reported some college or trade school, and two had achieved a 2 or 4 year college degree. Employment status was equally distributed (8 employed, 9 unemployed, 1 retired, and 1 volunteer). Length of clubhouse memberships ranged from 12 months or less to over 5 years, with an average of three years.

Procedures

Interviews were conducted using a semi-structured, open-ended protocol. Interviewers explored four central areas: the illness story, sources of social support, levels of clubhouse involvement, and recovery. Interviewers adapted each interview to meet the unique experiences and conditions of the interviewee (e.g., language, disability). Interview questions were designed to elicit personal stories from clubhouse members, but with little interference from the interviewer (i.e., *"Tell me the story of your experience of having a mental illness"*). Field research staff followed up with specific questions about the member's social network and sources of emotional and instrumental support (i.e., *"Who are the most important people in your life? Who helps you when you need help? When you are upset? When you need someone to talk to or turn to, how does that work for you? How do others turn to you for support?"*) Clubhouse members were then asked to provide a story about finding the clubhouse (e.g., *"Can you tell me the story of how you became involved with the clubhouse?"*). Finally, they were asked to discuss how the clubhouse facilitated experiences of recovery and to identify people and activities that supported their recovery. Narratives were audio-recorded and transcribed by field research staff and imported into NVivo*7 software (QSR International, 2006). Identifying and

confidential information were removed from the transcripts.

Saturation was expected when a thorough understanding of the ways in which clubhouses facilitate support for members was achieved. Saturation was reached before all 20 interviews were conducted, yet all interviews were completed to fulfill the commitment to interview all participants. These interviews capitulated common and consistent stories of how the clubhouse helps members, and by the final interview, no novel information emerged.

Trustworthiness and Data Analysis

The trustworthiness and credibility of the findings was established in several ways. The researchers asked the clubhouse director to serve as key informant to help ensure that members who were approached for interviews would fit the criteria and therefore not be unduly stressed by the recruitment process. Field research staff participated in both the transcription and coding processes. Field research was gathered by trained interviewers familiar with the clubhouse environment and skilled at conducting sensitive interviews. Field staff were under the supervision and direction of the first two authors, who are known for qualitative methodology and clubhouse programming, respectively. The analysis process included the first two authors working with the research team to produce a master document of pre-coded themes. Transcripts were read and re-read and coded independently by each of the members of the field research team. Consensus of the coding process was achieved both in face to face meetings and by using the software functions of NVIVO*7 that allow for inter-rater reliability. All major themes were determined by seeking prevalence and pervasiveness in the data. Finally, to demonstrate aspects of confirmability, all major themes presented in this

study are illustrated with direct quotations.

Analysis was conducted based on a modified grounded theory approach, using aspects of both deductive and inductive methods (Charmaz, 2002; Glaser & Strauss, 1967). Three waves of analysis were initiated. First, the research questions were used to guide deductive analysis and pre-codes were established to search for common themes. Second, open coding was initiated for purposes of inductive analysis and used with the assistance of NVIVO*7 software. Open coding yielded 36 initial codes. Pre-codes based on the research questions and initial codes were then compared and finalized into broader categories.

Finally, the categories were combined into 10 descriptive themes using the process of thematic analysis (Braun & Clarke, 2006). At each point in the coding process, the research team would meet and achieve consensus about codes before moving forward. Coding was a collaborative process and all final codes were determined by following a consensual process (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005).

————

Results

The analysis uncovered the role of the clubhouse setting as a central means of sustaining social support for its membership. The staff, the members, and the overall clubhouse environment emerged as the center of social interaction and comfort for those who participated in the interviews. Specifically, clubhouse members identified the clubhouse environment as facilitating personal growth and creating a safe and comfortable environment for its membership.

Data was organized under two overarching areas that characterize personal

stories and narratives of experiences of support and recovery: (1) the clubhouse environment and (2) opportunities for growth. Four primary sub-themes emerged from the personal stories that identified the clubhouse as *a place* to be, *a place* that facilitates personal growth, and *a place* to engage and interact with others. The sampling of illustrative quotes below demonstrates the actual voices of the participants and illustrates how each theme was articulated by members of the sample.

Clubhouse Environment

The narratives identified the clubhouse environment as facilitative of social involvement and personal growth. Pervasive findings pertaining to this context included the importance of the clubhouse organizational and social structure, and the benefits associated with membership, such as having a place that is accessible, welcoming, and available for members living in the community. Sub-themes supporting these findings are presented below.

A place to be. Clubhouse members expressed the belief that the clubhouse was a place that helped to facilitate and improve the quality of their lives. Participants noted that the environment provided *a good place to be.* It is noteworthy that participants were motivated to attend the clubhouse and engage in the life of the program as illustrated by the following statements:

> I think it is very helpful for me to come here. To help me deal with stuff, and I am glad because if not, I'd probably be in the hospital again.

Being with others similar to oneself served as the impetus for coming to the clubhouse as one member expressed:

> I just like to be around here. Just to be with other people, socialize with other

people who have problems similar to yours, people that understand you.

Another aspect of the environment was that it emphasizes a positive frame of mind by engaging in positive coping, modeling alternative ways of interacting and placing less emphasis on the illness. This was stated by another member in this way:

> Here I am focusing on the positive things all the time and that is very important to me because I am always negative.

Clubhouse structure. Emerging from these personal stories was an underlying theme reflecting the importance of the clubhouse's organizational structure as a non-coercive environment and a setting that was flexible and responsive to the rehabilitation and recovery needs of the individual. The structure associated with the work-ordered day provided a variety of meaningful tasks that, in part, drew members to the clubhouse. One member says:

> ...the clubhouse, a place to come and have friends, and wanting a place to type, stuff like that. Keeps me going. Gives me something to do instead of thinking about my problems all the time. Cook a good meal. They don't force you to volunteer for anything... Letting you work at your own pace; come out of your shell at your own pace. I prefer clerical work over kitchen work. I like banking work too.

Program environments that rely on implicit coercion can foster resistance and resentment among its consumers. In contrast, members in this study emphasized how clubhouses provide real and meaningful opportunities for learning that involved members testing out choices, experiencing consequences, and assessing the behavior and decision to change. A quote that describes what the clubhouse does follows:

> Helping me to do volunteer work. Letting me get back into it at my own

pace, not just like someone drop kicking me into the deep end of the pool and swim or sink. It's like I can gradually test the water out and see if I want to get submerged or not. Ya know, like the kid that doesn't want to swim. At first it's like "Oh, that water's cold." But this time it's like "oh, that water's warm" and so I slowly submerge myself into it and not get pushed into it by fate by an uncaring world.

Members frequently talked about qualities of the clubhouse structure that facilitated the mastery of skill development congruent with the pace of their own recovery. The environment was often described as *flexible* and encouraging self-regulatory skills congruent to members' recovery process:

> When I got laid off from Work Skills...they give you a lot of work to do, whatever you want to do, you can do it here. And sometimes you can socialize and have a cup of coffee or pop and talk for minute. That is what is good about this; it is a flexible workplace.

In addition, a helpful structure noted by members are the community employment options available through transitional employment:

> They can help with employment....like helping to find a job.

Thus it is through the structure of the clubhouse activities and a setting that is strongly grounded on the work-ordered day and transitional employment that members begin to fill their life with experiences that may motivate them to continue their personal growth.

> Structure is important. It's time to do this, do I need to take my meds, ok it's time to do that. Instead of having too much free time on my hands it keeps me engaged and accomplishing and succeeding....it's a good structure program, and I think it's helped.

Opportunities for Growth

Given that the flexibility of the clubhouse structure was observed as a way of providing greater opportunities to engage in skill development, it follows that it would also relate to a sense of personal efficacy and a greater sense of empowerment. The unique opportunities couched within this context may be associated with personal growth through the practice and remediation of these skills in a non-threatening and supportive environment.

A place to grow. Participants expressed the belief that the clubhouse allowed them to expand their repertoire of skills. These real opportunities to develop social skills, interests, and recreational interests emerged in their personal stories, often directly related to a member's sense of self-worth. For example, the following comment illustrates this point:

> Well, yeah gaining more skills that you didn't have previously and accessing them here...like typing and stuff like that...You can work on areas of your life and get a job...if they come here and they want to work towards a goal, they can do that. Like me, now I'm trying to work on a goal of learning how to type. Maybe I'll do the data processing at home, and stuff like that.

Members in ICCD clubhouses are supported to take on new roles such as serving on the local mental health board, giving talks to college classes and at conferences.

> I was picked for [this] county. ...for achievements and things I have done. I was surprised...300 people. That's the New Me. That's another thing I want to get good at...learn how to speak in front of people, and say what I want to say without notes...and be good.

This member expressed a similar story about the importance of *real and meaningful experiences* in life.

> Everything I do here has helped me to recover and it gave me myself back, and that's really good...it has helped me every step of the way...All of this has helped because I don't have any outside support...being able to talk...it's all helped me to recover...I know I have a lot more to learn and a lot farther to go....but now I know I can do it.

Meaningful involvement in the clubhouse environment also emerged as a core function of the clubhouse structure. Meaningful involvement also allowed for increased reciprocity of support among clubhouse members. Members moved away from the positions of being passive recipients of support and more towards providers of support by engaging and working with others. This sentiment is reflected in the following comment:

> Helping others helps me not to think about my problems. I feel like I have a purpose and can help others. It feels nice to do that when you are usually the one who needs help from others.

In response to what members often see as their role in the clubhouse, many identified the opportunity to help others and reciprocate support as central to their role:

> It is to help people with mental illness...sometimes I share my experiences with them and they do the same, you know; just try to be supportive, mostly to just talk to me and you know, be supportive.

A place to interact with others. Participants talked about the ways in which the clubhouse helped them to have contact with others like them and to build relationships and social capital for its clubhouse community. Social capital can be facilitated by community engagement, a core element of community-based peer programs. This experience is highlighted by one member's comment about greater involvement and feeling a sense of inclusion in the larger community:

I just think I have been more independent and more involved in the community and forming positive relationships since coming here.

I just like to be around here. Associate with people ya know. Talking about things with people. Not worrying somebody's gonna go running down the street or whatever yelling "hey, did you hear about [that girl] today, she's off her medication. They're coming to take her away." Just to be with other people, socialize with others who have problems similar to yours, people that understand you.

I live in [town], and a few of [the members] have jobs nearby, and once in a while, I see them around, walking and stuff and I talk to them. They play a big part. They help me accept my illness, and they also help reinforce that feeling once in a while too.

Opportunities to meet new people and develop friendships emerged as a significant theme in the lived experiences of these clubhouse members. For example, socializing was an important part of the clubhouse—serving as the impetus for engagement and involvement in the clubhouse activities as well as supporting the momentum for recovery:

> A place where I could hang out and meet new friends. It's just a place to go to hang out...meet different people and have a good time.

> I feel accepted here. I remember coming here on my third visit and I was talking to one of the staff and I remember saying that I don't like to talk about my mental illness, and she was like, why not? And I remember thinking, maybe she is on to something, and I realized it would feel good to talk about it. And here, they understand.

> I was a heroin addict and an alcoholic, and I think about shooting up every day and drinking every day.... But, talking to people helps me with that. It makes it easier and it makes your brain go off from that thought. If you stay busy and

talk to people, you get your mind off it. Clubhouse helps my illness a lot, and talking helps it, too, talking also helps my addiction. Because if I was sitting in my apartment, I will go right back to thinking about the drugs and alcohol. They help me out and I help them, or learn something.

The importance of building meaningful relationships that lead to experiences of recovery is further illustrated by this member:

It has helped me learn things about life, and how positive relationships should be. [Clubhouse] is a place for friendship.

Staff are important. A unique element of clubhouses as intentional recovery communities is the presence of professional staff – who not only work "along-side" members – but are also crucial in creating the experiences that facilitate recovery. Members characterized clubhouse staff in their personal stories as playing an important part in the clubhouse by serving essential roles in the development of skills, positive coping mechanisms and the provision of social support, particularly during a difficult time.

If I have any problems, I will go to the staff and tell them what is going on...they help me straighten it out and deal with it...I go out and talk to other people but they might not listen as well. I feel more comfortable talking to [staff].

...[the clubhouse] teaches you to do activities... I think it's pretty good for people...you can learn a lot...you learn computer skills, you learn how to cook, and social skills. You can talk to people, and if you have a problem, you talk to the director and staff, and they will help you with their experiences.

Stories also revealed the unique and responsive ways that staff established an organizational climate reflecting resiliency and recovery. Members perceived staff as promoting many of

SAMHSA's recovery components (2006) such as the importance of self-direction, empowerment, and strength-based approaches in their day to day interactions.

Members described staff as promoting greater positive expectations about themselves—often challenging members to revise their own self schema from one of illness and deficit to that of purpose and meaning. By placing importance on the role of work and working together, staff encouraged interactions that may have not naturally occurred for many members. For example, one clubhouse member described how other relationships in their life improved as a result of the interactions and socialization experiences afforded with staff support.

Staff gave me new life. They were caring, honest, and they helped me get my trust back. Staff got me talking again. My kids now recognize how well I'm doing. [Staff] are like a friend...family and caring – [staff] helped me to trust and I don't feel judged.

Another member reflected on the positive changes that he had made with staff support:

...I would walk when I get mad...sometimes I talk to staff when I had problems...it is all part of my symptoms and I think I have come a long way in managing...because back when I was in school, people used to make fun of me...just tease me and put me down...and we don't do that here. We are supportive...and are careful in what we say and do...

Genuine, non-judgmental interactions provided a foundation for members to rebuild trusting relationships with others, reflecting SAMHSA's recovery components of *disclosure, trust, and mutual support.* As one member noted, *"staff are good at relating to us; they know what we go through."* This was reflective of the ways that staff reach

out to members and normalize many of the feelings and behaviors.

[Staff member] was always there for me. I guess you can say that she would talk a lot about the things that are troubling me and she would help me figure it out, fix it, or be comfortable. But, she was always there to talk with me.

They try to help you out. I don't know if you would consider them friends or people close to you, though, but I consider them friends. I feel like they are my friends.

I think they genuinely want to help me out...um, [staff member], I've gone to for confiding, I guess. I was having a real hard time and [staff member] knew about it, that I was having a real bad time so we came in here and we talked so, I'm appreciative of what he was trying to do with me.

[Staff member] helps me problem solve and stuff. He makes me feel normal.

Conclusions and Implications for Practice

Overall, this qualitative study further documented the clubhouse model as an intentional recovery community for individuals with mental illness. Moos (2003) argues that a common set of programmatic characteristics underlie the power of treatment settings to affect their participants. These include the (1) quality of personal relationships, (2) directions of personal growth, and (3) level of clarity, structure, and openness to change. These characteristics are quite consistent with the qualities of clubhouses that emerged from members' descriptions and echo similar findings from other qualitative studies involving clubhouses and recovery communities (e.g., Whitely, Harris, Fallot, & Berley, 2008). These aspects of the treatment environment may be arguably some of the most significant ingredients that influence the dynamic and interpersonal

environment of the clubhouse. In this context, members are able to socialize and form relationships. Clubhouses provide environments that include opportunities that range from having a place to be and people to be there with to a place to build strong and supportive social networks.

Many responses reflected specific ways in which staff facilitated growth, resiliency, and recovery for the membership. Although a limitation of this approach is that it involved one clubhouse, it provides an initial framework for further investigation and valuable first-person accounts of phenomena pertaining to mental illness and recovery (Davidson, Haglund, Stayner, Rakfeldt, Chinman & Tebes, 2005; Davidson, Sells, Songster, & O'Connell, 2005). Ridgway's (2001) qualitative findings involving the *restoring of psychiatric disability* identified key elements of the recovery process and influenced the many ways institutional systems have come to define strength-oriented treatment environments (Onken, Craig, Ridgway, Ralph, & Cook, 2007). According to Ridgway, "resilience and recovery are highly contextual" and thus "narrative accounts challenge the field to critically examine institutional structures and processes (p. 342)." The current study examined the narratives of clubhouse members to demonstrate how recovery is linked *to a place*—that is, a clubhouse organizational environment.

A Place to Be, Grow, and Connect

These findings echo other studies involving clubhouses and stress the importance of interpersonal relationships in overcoming the isolation of mental illness (Waegemakers Schiff et al., 2008). An environmental structure imposed by a model emphasizing egalitarian relationships, personal growth through work, and rehabilitation through social relationships, may in

part influence these outcomes. Members often describe these recovery communities as "feeling like home" (Herman et al., 2005) or serving as "surrogate families" (Whitely et al., 2010), suggesting these environments engender cohesive social networks to support resiliency and recovery. For instance, Carpentier and White (2002) found that individuals belonging to more cohesive social networks were more likely to seek psychiatric services and maintain clinical follow-up.

The clubhouse has both clarity of structure, yet is flexible, allowing members the chance to build relationships and grow at their own pace. One of the major areas examined by the International Center for Clubhouse Development (ICCD) involves relationships. Given that this clubhouse successfully achieved ICCD certification suggests an awareness of the importance of relationships. The standards emphasize staff and members engaged in decision making, daily tasks, and all operations of the clubhouse. This may translate into practice when staff support is likely to enhance competency and sense of self-efficacy. This in turn allows members to feel valued by others and engage in the shared work of the clubhouse and to meet their own needs within the context of a supportive environment.

References

Beard, J. H., Propst, R., & Malamud, T. J. (1982). The Fountain House model of psychiatric rehabilitation. *Psychosocial Rehabilitation Journal, 5,* 47–53.

Bellack, A. S., & Mueser, K. T. (1993). Psychosocial treatment for schizophrenia. *Schizophrenia Bulletin, 19,* 317–336.

Borge, L., Martinsen, E., Ruud, T., Watne, O., & Friis, S. (1999). Quality of life, loneliness, and social contact among long-term psychiatric patients. *Psychiatric Services, 50,* 81–84.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology, 22*(6), 723–742.

Brugha, T. (1995). Social support and psychiatric disorder: Overview of evidence. In T. Brugha (Ed.), *Social support and psychiatric disorder: Research findings and guidelines for clinical practice* (pp. 1–40). Cambridge, MA: Cambridge University Press.

Carpentier, N. & White, D. (2002). Cohesion of the primary social network and sustained service use before the first psychiatric hospitalization. *The Journal of Behavioral Health Services & Research, 29*(4), 404–418.

Charmaz, K. (2002). Qualitative interviewing and grounded theory analysis. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research, context and method* (pp. 675–694). Thousand Oaks: Sage.

Corrigan, P. W. & Phelan, S. M. (2004). Social support and recovery in people with serious mental illness. *Community Mental Health Journal, 40*(6), 513–523.

Cresswell, J. W. (2007). *Qualitative inquiry and research design*. Thousand Oaks: Sage.

Davidson, L., Haglund, K. E., Stayner, D. A., Rakfeldt, J., Chinman, M. J. & Tebes, J. K. (2005). "It was just realizing...that life isn't one big horror": A qualitative study of supported socialization. In L. Davidson, C. Harding, & L. Spaniol (Eds.), *Recovery from severe mental illnesses: Research evidence and implications for practice, Volume 1* (pp. 377–411). Boston: Center for Psychiatric Rehabilitation, Boston University.

Davidson, L., Sells, D., Songster, S., & O'Connell, M. (2005). Qualitative studies of recovery: What can we learn from the person? In R. O. Ralph & P. W. Corrigan (Eds.), *Recovery in mental illness: Broadening our understanding of wellness* (pp. 147–170). Washington, DC, US: American Psychological Association.

Evert, H., Harvey, C., Trauer, T., & Herrman, H. (2003). The relationship between social networks and occupational and self-care functioning in people with psychosis. *Social Psychiatry & Psychiatric Epidemiology, 38*, 180–188.

Glaser, B. G., & Strauss, A. L. (1967) *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Publishing Company.

Hardiman, E. (2004). Networks of caring: A qualitative study of social support in consumer run mental health agencies. *Qualitative Social Work, 3*, 431–448.

Hawkely, L. C., & Cacioppo, J. T. (2010). Loneliness matters: A theoretical and empirical review of consequences and mechanisms. *Annals of Behavioral Medicine, 40*, 218–227.

Hendryx, M., Green, C. & Perrin, N. (2009). Social support, activities, and recovery from serious mental illness: STARS study findings. *The Journal of Behavioral Health Services & Research, 36*(3), 320–329.

Herman, S., Onaga, E., Pernice–Duca, F., Oh, S., & Ferguson, C. (2005). Sense of community in clubhouse programs: Member and staff concepts. *American Journal of Community Psychology, 36*(3–4), 343–356.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005) Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*, 196–205.

Howard, L., Leese, M., & Thornicroft, G. (2000). Social networks and functional status in patients with psychosis. *Acta Psychiatrica Scandinavica, 102*, 376–385.

Kawachi, I., Kennedy, B. P., & Glass, R. (1999). Social capital and self-rated health: A contextual analysis. *American Journal of Public Health, 89*(8), 1187–1193.

Kilbourne, A. M., McCarthy, J. F., Post, E. P., Welsh, D. & Blow, F. C. (2007). Social support among veterans with serious mental illness. *Social Psychiatry and Psychiatric Epidemiology, 42*(8), 639–646.

Moos, R. (2003). Social contexts: Transcending their power and their fragility. *American Journal of Community Psychology, 31*, 1–13.

Norman, C. (2006). The Fountain House movement, an alternative rehabilitation model for people with mental health problems, members' description of what works. *Scandinavian Journal of Caring Sciences, 20*(2), 184–192.

Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal, 31*(1), 9–22.

QSR (2006). Retrieved December 10, 2010 from http://www.qsrinternational.com/FileResourceHandler.ashx/RelatedDocuments/DocumentFile/480/NVivo7.pdf

Pernice-Duca, F. (2008). The structure and quality of social network support among mental health consumers of clubhouse programs. *Journal of Community Psychology, 36*, 929–946.

Pernice-Duca, F., & Onaga, E. O. (2009). Examining the contribution of social network support to the recovery process among clubhouse members. *American Journal of Psychiatric Rehabilitation, 12*(1), 1–30.

Rappaport, J. (1993). Narrative studies, personal stories, and identity transformation in the mutual help context. *The Journal of Applied Behavioral Science, 29*, 239–256.

Rappaport, J. (1995). Empowerment meets narrative: Listening to stories and creating settings. *American Journal of Community Psychology, 23*(5), 795–807.

Rappaport, J. (2000). Community narratives: Tales of terror and joy. *American Journal of Community Psychology, 28*(1), 1–24.

Ridgway, P. (2001). Restorying psychiatric disability: Learning from first person recovery narratives. *Psychiatric Rehabilitation Journal, 24*(4), 335–343.

Staeheli, M., Stayner, D., & Davidson, L. (2004). Pathways to friendship in the lives of people with psychosis: Incorporating narrative into experimental research. *Journal of Phenomenological Psychology, 35*(2), 233–252.

Substance Abuse and Mental Health Services Administration (SAMHSA, 2006). Consensus statement on recovery. Retrieved December 22, 2010 from http://www.samhsa.gov/SAMHSA

Waegemakers Schiff, J., Coleman, H., & Miner, D. (2008). Voluntary participation in rehabilitation: Lessons learned from a clubhouse environment. *Canadian Journal of Community Mental Health, 27*(1), 65–78.

Whitely, R., & McKenzie, K. (2005). Social capital and psychiatry: Review of the literature. *Harvard Review of Psychiatry, 13*, 71–84.

Whitely, R., Harris, M., Fallot, R. D., & Berley, R. W. (2008). The active ingredients of intentional recovery communities: Focus group evaluation. *Journal of Mental Health, 17*(2), 173–182.

Marsha T. Carolan, PhD, Associate Professor in Human Development and Family Studies, Michigan State University. Dr. Carolan's research involves qualitative research studies in family and community studies.

Esther E. Onaga, PhD, is an Associate Professor in the Department of Human Development and Family Studies at Michigan State University. She is director of the Family Impact Seminars and is involved in research around families, disabilities and clubhouses.

Francesca Pernice-Duca, PhD is an Assistant Professor at Wayne State University in the Department of Educational Psychology. She is the co-director of the Counseling Psychology graduate program and conducts research involving clubhouses and recovery.

Tiffeny Jimenez is a doctoral candidate at Michigan State University in Community Psychology.

Corresponding author:

Francesca Pernice-Duca, PhD
Assistant Professor and Co-Director
Counseling Psychology
Wayne State University
337 Education Building
Detroit, MI 48202
perniceduca@wayne.edu