INT'L. J. SELF-HELP & SELF-CARE, Vol. 7(1) 41-57, 2013

THE RELATIONSHIP BETWEEN SENSE OF MATTERING, STIGMA, AND RECOVERY: AN EMPIRICAL STUDY OF CLUBHOUSE PARTICIPANTS IN THE U.S. MIDWEST*

DEBORAH L. CONRAD-GARRISI, RN, PHD, LLP

FRANCESCA PERNICE-DUCA, PH.D.

Wayne State University, Detroit, Michigan

ABSTRACT

Individuals who experience a sense of mattering are more likely to experience higher levels of psychosocial well-being. Individuals with serious mental illness (SMI) often experience ostracism and social rejection rather than a sense of mattering, partly due to the stigma associated with SMI. Examining sense of mattering as a component of social support is a contribution of this study. Clubhouses provide support and assistance to individuals with SMI. The clubhouse program provides an intentional environment that creates a sense of community and offers an opportunity to develop sense of mattering, build skills, and develop peer relationships, which promotes recovery. A sample of 143 clubhouse members from 10 clubhouses participated in interviews about experiences of being a clubhouse member; perceptions of sense of mattering, stigma, and recovery. Results confirmed a sense of mattering is predictive of a subjective recovery. Individuals that experience a greater sense of mattering experienced less perceived stigma.

*This study is part of a Dissertation completed by the first author to fulfill requirements for a Doctorate in Philosophy in Educational Psychology at Wayne State University.

© 2013, Baywood Publishing Co., Inc.
doi: http://dx.doi.org/10.2190/SH.7.1.d
http://baywood.com

The phenomenon of recovery from serious mental illness (SMI) has emerged from consumers of mental health and psychiatric services, public health policies, and data from longitudinal studies (Corrigan & Ralph, 2005; Davidson, Tondura, O'Connell, Kirk, Rockholz, & Evans, 2007; Onken, Craig, Ridgway, Ralph, & Cook, 2007). Recovery has been conceptualized in numerous ways; however, the definition of recovery that is most meaningful to the consumers of mental health treatment includes the presence of hope and meaning in life, developing a sense of identity apart from the illness, empowerment, being supported by others, and overcoming the effects of discrimination (Kidd, George, O'Connell, Sylvestre, Kirkpatrick, Brown, et al., 2011, Sheedy & Whitter, 2009).

A significant aspect of recovery includes the capacity to access and utilize sources of social support, such as those from peers, families, and support groups. Social support is one of the most explored constructs in mental health research (Turner & Marino, 1994) and is considered essential to recovery (Corrigan & Phelan, 2004; Pernice-Duca, 2008; Turner & Marino, 1994; Young & Ensing, 1999). It is also conceptualized as a "meta construct" (Turner & Marino, 1994, p. 195) and includes such dimensions as social networks, social support, and supportive behavior. Researchers have found that perceptions of social support are more predictive of psychological, physical, and mental health well-being than objective or observed measures of social support (Roberts, Salem, Rappaport, Toro, Luke, & Seidman, 1999). Specifically, support from peers is an important aspect of the recovery process among people living with a severe mental illness (Biegel, Pernice-Duca, Chang, & D'Angelo, 2012).

An important yet distinct element of social support is the development of a "sense of mattering." Mattering is defined as "the feeling that others depend on us, are interested in us, are concerned with our fate, or experience us as an ego-extension" (Rosenburg & McCullough, 1981, p. 165). This suggests that mattering is part of a need to belong, a need to feel accepted, which has been described as a basic human motivation (Baumeister & Leary, 1995). As a proxy to social support, a sense of mattering to others or a mutual aid group facilitates mental health recovery. Mattering to others or to a mutual aid group also is related to less internalized stigma about living with a serious psychiatric disorder. Therefore, the current study examines the overall sense of mattering experienced with others and internalized self-stigma in relation to mental health recovery. It is theorized that sense of mattering is a construct that is important for recovery, yet has not been explored, specifically as a way to further understand the dynamics of social support. It is hypothesized that a greater sense of mattering is positively related to recovery but inversely related to stigma.

OBJECTIVES OF THE CURRENT STUDY

Individuals living with a serious mental health condition are often at the greatest risk of social rejection and isolation; the lack of being part of a community of

support can inhibit the development of the basic human motivation to belong (Baumeister & Leary, 1995). It is theorized that a sense of mattering develops from the experience of mutual aid and a sense of belonging occurring within Clubhouse environment (Herman, Onaga, Pernice-Duca, Oh, & Ferguson, 2005). It is suggested that individuals that experience a sense of mattering develop an important human connection that facilitates confidence and self-efficacy which assists in moving toward recovery. This human connection facilitates the development of identity and meaning and buffers against the negative effects of stigma associated with psychiatric illness.

The examination of a sense of mattering as a separate component of social support and its relationship with perceived stigma and recovery has not been done before. This study hypothesized that a sense of mattering would positively correlate with a subjective sense of recovery. Also, it was hypothesized that a sense of mattering has an inverse relationship with the experience of stigma. The hypotheses were tested in a sample of 143 voluntary participants from 10 clubhouses in a Midwestern state in the United States. Standardized and reliable measures of recovery, sense of mattering, and stigma that have been used previously in psychological research were used in testing the hypotheses. This article discusses the major concepts of recovery, stigma, and sense of mattering and the relevance to the research literature in psychology. In addition, the Clubhouse as a form of psychosocial rehabilitation and supportive environment is described. The methods and measurement used in the research are referenced followed by the findings and conclusions.

SENSE OF MATTERING AND BELONGING

The concept of "mattering" is defined as "the feeling that others depend on us, are interested in us, are concerned with our fate (Rosenburg & McCullough, 1981). *Sense of mattering* has been found to promote and elevate our self-concept, which in turn has been associated with greater sense of well-being, reciprocity of social support, and even job satisfaction (Rayle, 2006). The construct of mattering is based on three basic assumptions, the first of which is a primary need to be known and acknowledged from others. A second assumption is a sense of importance—that is, the sense that one matters or is the object of concern. By receiving the support one needs from other's, one can feel important to that person; that one matters. A third assumption is the notion that others depend on us and that we feel a sense of mutuality and obligation in our relationships, which reflects the importance of reciprocity in social integration (Pernice-Duca, 2010; Rosenberg & McCullogh, 1981). A sense of mattering is achieved when an individual feels that others are likely to turn to and rely on him or her (Elliot, Kao, & Grant, 2004). On the other hand, the absence of mattering in relationships can result in the perception of being insignificant and inconsequential (Rayle, 2006), thus leading to feelings of rejection and social isolation. A sense of

mattering is theorized to be essential to our sense of self (Elliot et al., 2004) and influences our actions and behaviors. It is posited that mattering is an important construct that explains how social support may influence recovery experiences.

It is noted that the concept of mattering may overlap with similar constructs such as interpersonal dependency, mastery, and perceived social support (Taylor & Turner, 2001). Although this suggests some overlap between mattering and social support, there is some evidence that mattering is a unique contributor to well-being and offers a protective factor (Taylor & Turner, 2001, p. 323). Those living with SMI may experience alienation from society and may also experience less mattering. A sense of mattering is believed to be crucial in promoting the recovery process by providing a sense of importance and purpose through the experience of: (a) being attended to, (b) concerned about, and (c) regarded as significant.

RECOVERY

The Federal Office of Substance Abuse and Mental Health Services Administration (SAMHSA, 2006) in the United States provides one of the most frequently used definitions of recovery for the development of public policy and community treatment (Lysaker, Roe, & Buck, 2010). A majority of the components fundamental to recovery identify the individual's perception and role in the recovery process as well as the importance of social support networks and support from other consumers. Accordingly, the emphasis for treatment is placed on a "strengths-based," "person-centered," "holistic," "peer support" approach, with the consumer of the services taking "responsibility," "self-direction," and being "empowered" (http://store.samhsa.gov/product/SMA05-4129).

Recovery is seen as "non-linear," a process that sees growth as well as regression with opportunities to learn from experiences (http://store.samhsa.gov/product/SMA05-4129). This definition has cross-cultural relevance. For example, Chiu, Ho, Lo, and Yiu (2010) used the SAMHSA recovery model in their research on recovery in Hong Kong.

STIGMA

Previous studies have shown that greater overall well-being is associated with lower perceived stigma of living with a serious mental illness (Crespo, Perez-Santos, Munoz, & Guillen, 2008; King, Dinos, Shaw, Watson, Stevens, Passetti, et al., 2007). The stigma associated with mental illness is global—with research across nations finding consistent results that individuals with serious mental illness are devalued in society (Thronicroft, Brohan, Rose, Satorius, & Leese, 2009). Lack of knowledge, prejudicial attitudes, and discrimination are aspects of stigma that result in "impoverishment, social marginalization, and low quality of life" (Thornicroft et al., 2009, p. 408) for those that experience stigma.

Stigma also has a negative impact on self-esteem, life satisfaction, and severity of psychiatric symptoms (Markowitz, 2001). The effects of stigma may be the result of either persistent social rejection or the development of a "stigmatized self-concept" that can result in self-stigma (Wright, Grofein, & Owens, 2000, p. 71). Individuals with serious mental illness (SMI) that experience self-stigma believe that he or she is not as important as others. Self-stigma is also associated with low self-esteem, increase in psychological distress (Lysaker et al., 2010), and recurrent psychosocial problems (Wright et al., 2000). Stigma also operates as a barrier to utilizing mental health services (Lieberman, Kopelowicz, Ventura, & Gutkind, 2002), reaching out for assistance (Perlick, Rosenheck, Clarkin, Sirey, Salahi, Struening, et al., 2001), or community engagement (Verhaeghe, Bracke, & Bruynooghe, 2008), which can affect one's recovery experiences. Self-stigma has been found as a barrier to recovery among individuals with schizophrenia (Brohan, Elgie, Satorius, & Thornicroft, 2010). Brohan et al. (2010) found in their study across 14 European countries that a reduction in self-stigma was significantly correlated with empowerment and more social contacts. Psychosocial rehabilitation programs, such as clubhouses, provide an opportunity for social contact and interaction as well as offer refuge as a place to belong (Carolan, Onaga, Pernice-Duca, & Jiminez, 2011).

CLUBHOUSES

Clubhouses are a form of psychosocial rehabilitation, which gained support in the aftermath of the deinstitutionalization movement and the development of community-based treatment programs designed to provide support and assistance to individuals with mental health disorders in their own community (Accordino, Porter, & Morse, 2001). The concept of the clubhouse began in 1943 by a group of psychiatric patients that developed a support group after being released from a state hospital (Macias, Jackson, Schroeder, & Wang, 1999; Mastboom, 1992). It eventually became known as the Fountain House and is still in operation today. The Fountain House provides support and purposeful activities focusing on achieving success in the outside world, as well as providing a safe haven from the discrimination and prejudicial attitudes of society.

Clubhouses exist throughout the world and many follow guidelines and policies of the non-profit organization known as the International Center for Clubhouse Development (ICCD). The clubhouse model "was conceived as an intentional therapeutic community composed both of people who have a serious mental illness and generalist staff who work within the clubhouse" (Macias et al., 1999). Clubhouses typically operate Monday through Friday during the day with some offering evening and weekend social and recreational activities. Participation is voluntary and there is an open enrollment policy. The only admission requirement is a diagnosis of a serious mental illness. Support services provided by the clubhouse include work of the clubhouse (e.g., clerical, kitchen,

maintenance), employment support, housing assistance, money management, individual advocacy, assistance with benefits, and opportunities for after-hour social activities (Macias et al., 1999). High fidelity clubhouses are characterized by a no-nonsense business like atmosphere with collegiality among staff and consumers working side-by-side on the business of the house (Pernice-Duca, Saxe, & Johnson, 2010).

Clubhouses started as a support group, similar to Alcoholic Anonymous in that everyone in the group shared a common experience and concerns. The effectiveness of support groups is based on the concept of mutual aid (Ngai, Cheung, & Ngai, 2009). Mutual aid is experienced when members of the group offer hope, "trust and acceptance, which requires an ability to convey to others their worth, express care and interest, and offer helpful empathic suggestions" (Ngai et al., 2009, p. 449). One way mutual aid develops is through participation in meaningful activities in which members experience success through collaboration (Ngai et al., 2009). Clubhouses provide an intentional environment whereby members collaborate with each other in the management and maintenance of the clubhouse (Mowbray, Lewandowski, Holter, & Bybee, 2006).

Clubhouses differ from support groups in that the Clubhouse employs mental health professionals, although the relationship between staff and members is designed to be equal and non-hierarchical. Mental health staff are able to offer resources and support in the running of the clubhouse. It has been suggested that the input from mental health staff, such as identifying common concerns, facilitating interaction, and offering support, promotes the development of mutual aid within the group (Ngai et al., 2009).

METHOD

Procedure

The study was conducted in a Midwestern state in the United States of America. All procedures and measures received approval by the university's committee to protect human subjects. A letter of invitation was sent via e-mail to a sample of clubhouses within the Midwest region of the United States explaining the purpose of the study and requirements of participation. Interested clubhouses contacted the first author via e-mail and a date was set for the research team to come to the clubhouse.

The research team consisted of the first two authors, five graduate students, and a clubhouse consumer with a graduate degree. All members of the research team completed training to insure consistency in administration of survey instruments. Upon arrival at each clubhouse, the first author explained the purpose of the study and requirements of participation to the clubhouse members and introduced the research team. Members that chose to participate put their name on a sign-up sheet or approached a research assistant.

Semi-structured interviews were conducted at the clubhouse during program hours (9:00 am to 3:00 pm). Each research assistant met individually with a clubhouse member. Survey instruments and open-ended questions were read to each participant. No incentives were offered to participate and participation was considered consent. Interviews were conducted in a private area of the clubhouse to insure confidentiality and lasted between 45-60 minutes.

Measures

The measures used in this study are self-report instruments. Previous studies have found self-report instruments to be reliable and are "often recommended because they reflect the unique experience of the individuals" (Crane-Ross, Lutz, & Roth, 2006, p. 143). This study is interested in obtaining the subjective experience of the individual with SMI, thus the viewpoint of the individual is most important. The following measures have been used in previous research and were chosen due to their reliability and validity in measuring the constructs to be examined.

Demographics

Demographic information used for the current analysis includes age, gender, education, and marital status.

Recovery

The Recovery Assessment Scale (RAS; Corrigan, Giffort, Rashid, Leary, & Okeke, 1999) is a self-report measure that assesses an individual's subjective experience of recovery. The RAS was developed through narrative analysis of personal accounts of recovery from individuals with SMI and is frequently used as a measure of recovery (Corrigan et al., 1999; Corigan & Phelan, 2004). The RAS is a 41-item self-report measurement based on a 5-point scale (1 = strongly disagree to 5 = strongly agree) with five factors. Cronbach alphas for each factor for the current study are as follows:

1. personal confidence and hope ($\alpha = .61$);
2. willingness to ask for help ($\alpha = .82$);
3. goal and success orientation ($\alpha = .72$);
4. reliance on others ($\alpha = .73$); and
5. no domination by symptoms ($\alpha = .65$).

Mattering

The Sense of Mattering Scale (Elliot et al., 2004) consists of 24 items with responses based on a 5-point scale ("strongly agree" to "strongly disagree"). The scale includes three subscales that measure the basic assumptions of the mattering

construct: Awareness which is the primary need to be known and acknowledged; Importance, that one is the object of concern and is important enough to receive support; Reliance refers to the reciprocity in relationships, to not only receive support but also to be able to provide support to others. The higher the score, the greater degree of perceived mattering experienced. Cronbach alphas for the current study for each of the subscales are as follows: Reliance (α = 87), Awareness (α = .78), Importance (α = .86).

Perceived Social Support

The Support from Friends subscale from the *Multidimensional Scale of Perceived Social Support* (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988) was used to measure perceived support from friends. Responses to the items are rated on Likert 7-point scale from "very strongly disagree" to "very strongly agree." For the current study the Friend support subscale had a reliability coefficient of α = .96.

Stigma

The Stigma Scale (King et al., 2007) is a 28-item scale with responses ranging from "strongly disagree" to "strongly agree" and includes three subscales, which assess discrimination, disclosure, and positive aspects of mental illness. The Discrimination subscale focuses on the perceived hostility and prejudiced attitudes experienced by others. Disclosure items assess perceived stigma once others are aware of the individual's mental illness. The Positive Aspects subscale measures development of empathy and understanding toward others because of one's own experience with mental illness. Test-retest reliability of each statement was determined using k coefficient and ranged from above .4 to .71 (King et al., 2007). The Cronbach's alphas for each of the subscales for the current study are as follows: Discrimination (α = .88), Disclosure (α = .69), Positive aspects (α = .59).

RESULTS

Sample

Clubhouses

Ten clubhouses participated. Two were accredited by the ICCD certified and nine clubhouses had directors trained in the ICCD model and followed the ICCD standards. All clubhouses operated the work-order day, with at least four different units including kitchen, clerical, maintenance, and employment units. Every clubhouse in the sample had community meetings run by the members and staff. The average number of participants from each clubhouse was 14.3, spanning between 3 and 24 members.

Members

A total of 143 members across the 10 clubhouses participated in the interviews. The average length of clubhouse membership was 5.16 years with a median of 3 years. Clubhouse members reported coming to the clubhouse an average of 4 days a week (mean = 3.8,) and spending an average of 5 hours a day at the clubhouse (mean = 5.5). Member demographics and participation are similar to those reported in other studies involving clubhouse members (see Table 1) (Mowbray et al., 2006; Pernice-Duca, 2010). The percentage of male and female participants was almost equal (male = 54%). The age of the participants spanned from 19 to 73 years old with the mean age at 47.1 years. A majority of the sample was Caucasian (75.5%). Fifty-seven percent reported having no children.

A majority of the participants (40.6%) live with family members, while 31.2% live alone and 27.3% have a roommate. Most participants completed high school or obtained the equivalent of a high school diploma (31.5%), while 46.2% reported some college, including associate, bachelor, or master degrees or

Table 1. Clubhouse Participant Demographics (N = 143)

Characteristics	Categories	*N*	%
Age	Range 19-73 yrs		
(M = 47 yrs)	19-30 yrs	19	13
	21-50 yrs	55	39
	Over 50 yrs	68	48
Gender	Male	77	55
	Female	64	45
Race	African-American	24	17
	Caucasian	108	76
	Other	11	8
Education	High school grad/GED	45	32
Living	Live alone	46	31
arrangements	Roommate/family	97	68
Marital status	Married	4	3
	Separated/Divorced/Widowed	48	34
Diagnosis	Schizophrenia and related disorders	61	45
	Mood affective disorders	59	55
Employment	Employed	28	20

vocational training; 14.7% reported completing less than a 12th grade education and 6.3% reported less than a 9th grade education. A majority of participants reported not working (80.3%).

Bivariate correlations were performed to examine the relationship between sense of mattering, stigma, and subjective recovery. Table 2 displays the correlation matrix of the variables in this study and descriptive statistics of independent and dependent variables. Multicollinearity among predictors was examined and deemed to be at an acceptable relationship based on recommendations of Tabachnik and Fidell (1996).

Analysis

Two separate multivariate regression models were conducted to test the proposed hypotheses, that the sense of mattering construct is a predictor to recovery and stigma. Regression analyses allows for the examination of the unique contribution of each predictor variable on the criterion. Key demographic variables that are related to the criterion variable based on the literature were included in the models tested.

> Hypothesis 1: *A perceived a sense of mattering is predictive of a subjective sense of recovery* (results are demonstrated in Model). To control for changes in recovery based on age or diagnosis, the member's age and a diagnosis of schizophrenia were entered first in the model, followed by Sense of Mattering factors, and support from friends. The model was significant, $R = .63$, $R^2 = .39$, $F(6, 120) = 12.19$, $p < .001$ (see Table 3). The

Table 2. Correlations among Variables ($N = 139$)

Measure	*M*	*SD*	1	2	3	4	5	6	7	8
1. RAS			—	–.48**	.44**	.43**	.40**	.44**	–.17	.24
2. Stigma				—	–.43**	–.34**	.19	–.16	–.07	–.15
3. Aware					—	.58**	.34**	.35**	–.11	.18*
4. Importance						—	.37**	.47**	–.07	.15
5. Reliance							—	.43**	–.18*	–.06*
6. Friends								—	–.05	–.04
7. Age									—	.08
8. DX										—

*$p < .05$. **$p < .01$.

Note: RAS = Recovery Assessment Scale; Stigma = Stigma Scale; Aware = Awareness subscale of Sense of Mattering (SOM); Importance = Importance subscale of SOM; Reliance = Reliance subscale of SOM; Friends = Friends Subscale of Multidimensional Scale of Perceived Support; Age = Consumer's age; DX = Diagnosis of Schizophrenia.

Table 3. Regression Analysis of Predicting Variables of Subjective Recovery

Variable	B	SE *B*	B	*t*	*p*
DX	.23	.07	.23**	3.03	.00
Age	–.00	.00	–.09	–1.20	.23
Awareness	.11	.08	.14	1.44	.15
Importance	.11	.08	.14	1.37	.17
Reliance	.14	.06	.22*	2.50	.01
Friends	.11	.05	.21*	2.30	.02

*$p < .05$. **$p < .01$.

Note: DX = Diagnosis of Schizophrenia, Age = Age of participant, Awareness = Awareness subscale of SOM, Importance = Importance subscale of SOM, Reliance = Reliance subscale of SOM, Friends = Friends Subscale of MSPSS.

Reliance subscale was the most important factor to emerge from the sense of mattering measure, followed by support from friends. This indicates that not only receiving social support from friends, but also being able to offer support and believing that others rely on you, is most predictive of a subjective sense of recovery. Member's age was not predictive of recovery; however, the presence of schizophrenia over other types of disorders has a positive relationship with recovery, indicating those who reported a diagnosis of schizophrenia were more likely to be in recovery.

Hypothesis 2: *Perceived sense of mattering has an inverse relationship with the experience of stigma* (results are demonstrated in Model 2). To examine the relationship between mattering and stigma, sense of mattering factors (i.e., awareness, reliance, importance) were entered separately, followed by support from friends. The model was significant in the hypothesized direction, $R = .44$, $R^2 = .20$, $F(4, 131) = 7.97$, $p < .001$. Interestingly, awareness from the mattering scale was the only significant predictor even though all the predictors correlated with the criterion variable (see Table 4). This suggests that experiencing a sense of positive acknowledgment from others rather that feeling ignored may protect from the effects of perceived stigma.

It was hypothesized that a sense of mattering plays a role in achieving recovery as well as reducing stigma. This is based on the notion that we, as human beings, need social interaction and social contacts to survive. However, social interaction is not enough to promote wellness; a sense of belonging or mattering to others is crucial in achieving mental health and stability (Baumeister

Table 4. Regression Analysis of Predicting Variables of Perceived Stigma

Variable	B	SE *B*	B	*t*	*p*
Awareness	–.31	.09	–.33	–3.34**	.00
Importance	–.15	.10	–.16	–1.54	.13
Reliance	–.04	.07	–.05	–.60	.54
Friends	043	.06	.07	.76	.45

*$p < .05$. **$p < .01$.

Note: Awareness = Awareness subscale of SOM, Importance = Importance subscale of SOM, Reliance = Reliance subscale of SOM, Friends = Friends Subscale of MSPSS.

& Leary, 1995). In fact, studies have found that the "absence of close or confiding relationships is associated with greater risk of relapse or non-remission among individuals with depression" (Perlick et al., 2001, p. 1631).

This study tested two hypotheses that examined the contributions of sense of mattering and social support on predicting recovery and stigma. The results of hypothesis 1 indicate that perceived social support, particularly from friends, and the presence of a bidirectional, reciprocal, sense of mattering relationship are most predictive of a subjective sense of recovery. The opportunity to not only receive but offer and provide support to others is crucial to the experience of recovery. The reciprocal relationships and sense that one is important reinforces several of the principles of recovery, including empowerment, respect, responsibility, and peer support (Oades, Crowe, & Nguyen, 2009).

The results of hypothesis 2 indicate that sense of mattering and awareness, or the sense that one is noticed and exists, is most predictive in minimizing perceived stigma. Stigma has been implicated as having a detrimental effect on self-esteem and self-efficacy, and in the development of social support (Fung, Tsang, Corrigan, Lam, & Cheng, 2007; Perlick et al., 2001; Verhaeghe et al., 2008). Stigma also has been found to discourage those with serious mental illness to interact with others, as well as compromise social functioning (Perlick et al., 2001). This study suggests that sense of mattering has an inverse relationship to perceived stigma. It is theorized that providing a more socially accepting and non-judgmental environment, along with relationships that promote self-acceptance, will buffer the negative effects of stigma. The clubhouse environment provides an intentional environment that creates a sense of community and a place to belong (Carolan et al., 2011). The current study introduced the construct of *mattering* as a possible correlate to the subjective experiences of recovery within the social support context of the clubhouse community. We found that the ability to go to a place where one can meet individuals in like situations has

been identified as very helpful in achieving recovery by providing the opportunity to "rebuild ones shattered social network, offering contact with others in the same situation" (Schön, Denhov, & Topor, 2009, p. 343). Attending and participating in the clubhouse provides an opportunity for consumers to experience mutual aid through the work of the clubhouse and exposure to the experiential knowledge of peers which provides an opportunity for consumers to be recognized, acknowledged, and to feel a sense of importance. Not just receiving support from peers, but also experiencing a sense that others rely on and depend on each other contributes to achieving a sense of recovery.

FUTURE DIRECTION/LIMITATIONS

This study identified that a sense of mattering and peer support, particularly from friends, plays an important role in recovery and reducing stigma. Self-stigma has been referred to as "the second illness" (Karidi, Stefanis, Theleritis, Rabavilas, & Stefanis, 2010, p. 28) to the barriers it creates in social roles and the development of relationships. Clubhouses may play an important role in reducing stigma and improving recovery. Psychosocial rehabilitation programs, such as clubhouses, provide an environment that fosters a sense of belonging and a sense of mattering and should be promoted. Previous research has found that identifying with a group may act as a shield in protecting individuals from stigma (Karidi et al., 2010, p. 28). Rosenfield (1997) examined the effects of receiving services at a clubhouse and perceived stigma on life satisfaction. Results indicate services offered at the clubhouse improved quality of life while perceived stigma decreased quality of life.

This study obtained data directly from the consumer using self-report measures and open-ended questions and did not compare reported information to objective measures. Recovery is a subjective experience and the perceptions of the individual are most relevant. However, the perspective of family and peers and their relationship with the individual with a mental illness would provide another dimension to understanding influential factors in the recovery process. The generalizability of results is limited since this study lacks a comparison group. In order to gain a better understanding of the role and the extent sense of mattering has on stigma and recovery, a comparison group of individuals with mental illness that do not attend clubhouses must be included. The perception of recovery and the relationships individuals with mental illness have without the support of the clubhouse would provide insight into the meaningful components of recovery. Recovery has been identified as a non-linear process, which suggests fluctuations occur. This study used a cross sectional design which is not sensitive to variations that occur over time. A longitudinal study would provide the opportunity to track the process of recovery and the impact of sense of mattering. The possibility of recovery opens the door for individuals with SMI to pursue goals, develop a sense of identity, and lead a meaningful

life. Further understanding of ways to promote recovery through relationships that encourage a sense of belonging, of mattering, will greatly benefit individuals with SMI.

ACKNOWLEDGMENTS

The first author would like to thank her advisors, Francesca Pernice-Duca, PhD and Stephen Hillman, PhD for their guidance and support, as well as the research team for their assistance and time in completing the interviews. The author would also like to thank the clubhouses and their members that participated in the study, giving their time and valuable insight.

REFERENCES

Accordino, M. P., Porter, D. F., & Morse, T. (2001). Deinstitutionalization of persons with severe illness: Context and consequences. *Journal of Rehabilitation, 67*(2), 16-21.

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin, 117*(3), 497-529.

Biegel, B. E., Pernice-Duca, F., Chang, C., & D'Angelo, L. (2012). Peer supports in an urban clubhouse. *Community Mental Health Journal, 48*(2), 153-160. doi: 10.1007/s10597-012-9502-5

Brohan, E., Elgie, R., Satorius, N., & Thornicroft, G. (2010). Self-stigma, environment and perceived discrimination among people with schizophrenia in 14 European countries: The GAMIAN-Europe study. *Schizophrenia Research 122*, 232-238.

Carolan, M., Onaga, E., Pernice-Duca, F., & Jimenez, T. (2011). A place to be: The role of clubhouses in facilitating support. *Psychiatric Rehabilitation Journal, 35*(2), 125-132.

Chiu, M. Y., Ho, W. W., Lo, W. T., & Yiu, M. C. (2010). Operationalization of the SAMHSA model of recovery: A quality of life perspective. *Quality of Life Research, 19*, 1-13.

Corrigan, P. W., Giffort, D., Rashid, F., Leary, M., & Okeke, I. (1999). Recovery as a psychological construct. *Community Mental Health Journal, 35*(3), 231-239.

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

Corrigan, P. W., & Ralph, R. O. (2005). *Recovery in mental illness: Broadening our understanding of wellness* (pp. 3-17). Washington, DC: American Psychological Association.

Crane-Ross, D., Lutz, W. J., & Roth, D. (2006). Consumer and case manager perspectives of service empowerment: Relationship to mental health recovery. *Journal of Behavioral Health Services & Research, 33*(2), 142-155.

Crespo, M., Perez-Santos, E., Munoz, M., & Guillen, A. I. (2008). Descriptive study of stigma associated with severe and persistent mental illness among the general population of Madrid (Spain). *Community Mental Health Journal, 44*, 393-403.

Davidson, L., Tondura, J., O'Connell, M., Kirk Jr., T., Rockholz, P., & Evans, A. C. (2007). Creating a recovery oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal, 31*(1), 23-31.

Elliot, G. C., Kao, S., & Grant, A. M. (2004). Mattering: Empirical validation of a social-psychological concept. *Self and Identity, 3*, 339-354.

Fung, K., Tsang, H., Corrigan, P., Lam, C., & Cheng, W. (2007). Measuring self-stigma of mental illness in China and its implications for recovery. *International Journal of Social Psychiatry, 53*(3), 408-418.

Herman, S. E., 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.

Karidi, M. V., Stefanis, C. N., Theleritis, M., Rabavilas, A. D., & Stefanis, N. C. (2010). Perceived stigma, self-concept, and self-stigmatization of patient with schizophrenia. *Comprehensive Psychiatry, 51*, 19-30.

Kidd, S. A., George, L., O'Connell, M., Sylvestre, J., Kirkpatrick, H., Browne, G., et al. (2011). Recovery-oriented service provision and clinical outcomes in assertive community treatment. *Psychiatric Rehabilitation Journal, 34*(3), 194-201.

King, M., Dinos, S., Shaw, J., Watson, R., Stevens, S., Passetti, F., et al. (2007). The stigma scale: Development of a standardized measure of the stigma of mental illness. *The British Journal of Psychiatry, 190,* 248-254.

Liberman, R. P., Kopelowicz, A., Ventura, J., & Gutkind, D. (2002). Operational criteria and factors related to recovery from schizophrenia. *International Review of Psychiatry, 14*, 256-272.

Lysaker, P. H., Roe, D., & Buck, K. D. (2010). Recovery and wellness amid schizophrenia: Definitions evidence, and the implications for clinical practice. *Journal of the American Psychiatric Nurses Association, 16*(1), 36-42.

Macias, C., Jackson, R., Schroeder, C., & Wang, Q. (1999). What is a clubhouse? Report on the ICCD 1996 survey of USA clubhouses. *Community Mental Health Journal, 35*(2), 181-190.

Markowitz, F. (2001). Modeling processes in recovery from mental illness: Relationships between symptoms, life satisfaction, and self-concept. *Journal of Health and Social Behavior, 2*(1), 64-79.

Mastboom, J. (1992). Forty clubhouses: Model and practices. *Psychosocial Rehabilitation Journal, 16*(2), 9-23.

Mowbray, C. T., Lewandowski, L., Holter, M., & Bybee, D. (2006). The clubhouse as an empowering setting. *Health and Social Work, 31*(3), 167-179.

Ngai, A. S., Cheung, C., & Ngai, N. (2009). Building mutual aid among young people with emotional and behavioral problems: The experiences of Hong Kong social workers. *Adolescence, 44*(174), 447-463.

Oades, L. G., Crowe, T. P., & Nguyen, M. (2009). Leadership coaching transforming mental health systems from the inside out: The collaborative recovery model as person-centered strengths based coaching psychology. *International Coaching Psychology Review, 4*(1), 25-36.

Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R., & 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.

Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Sirey, J., Salahi, J., Struening, E. L., et al. (2001). Adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric Services, 52*(12), 1627-1632.

Pernice-Duca, F. M. (2008). The structure and quality of social network support among mental health consumers of clubhouse programs. *Journal of Community Psychology, 36*(7), 929-946.

Pernice-Duca, F. (2010). Staff and member perceptions of the clubhouse environment. *Administration and Policy in Mental Health and Mental Health Services Research, 37*(4), 345-356.

Pernice-Duca, F., Saxe, B., & Johnson, J. (2010). Factors influencing staff perceptions of the organizational environment of clubhouses. *Administration and Policy in Mental Health and Mental Health Services Research, 37*(4), 334-344.

Rayle, A. D. (2006). Mattering to others: Implications for the counseling relationship. *Journal of Counseling and Development, 84*, 483-487.

Roberts, L. J., Salem, D., Rappaport, J., Toro, P. A., Luke, D. A., & Seidman, E. (1999). Giving and receiving help: Interpersonal transactions in mutual-help meetings and psychosocial adjustments of members. *American Journal of Community Psychology, 27*(6), 841-868.

Rosenberg, M., & McCullough, C. (1981). Mattering: Inferred significance and mental health among adolescents. *Research in Community and Mental Health, 2*, 163-182.

Rosenfield, S. (1997, August). Labeling mental illness: The effects of received services and perceived stigma on life satisfaction. *American Sociological Review, 62*, 660-672.

Schön, U., Denhov, A., & Topor, A. (2009). Social relationships as a decisive factor in recovering from severe mental illness. *International Journal of Social Psychiatry, 55*(4), 336-347.

Sheedy, C. K., & Whitter, M. (2009). *Guiding principles and elements of recovery-oriented systems of care: What do we know from the research?* Substance Abuse and Mental Health Services Administration. Retrieved from http://pfr.samhsa.gov/docs/Guiding_Principles_Whitepaper.pdf

Substance Abuse and Mental Health Services (SAMHSA). (2006). *National consensus statement on mental health recovery.* Retrieved from http://store.samhsa.gov.product/SMA05-4129

Tabachnick, B. G., & Fidell, L. S. (1996). Using mulivariate statistics. New York, NY: HarperCollins.

Taylor, J., & Turner, R. J. (2001). A longitudinal study of the role and significance of mattering to others for depressive symptoms. *Journal of Health and Social Behavior, 42*, 310-325.

Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., & Leese, M. (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: A cross-sectional survey. *Lancet, 373*, 408-415.

Turner, R. J., & Marino, F. (1994). Social support structure: A descriptive epidemiology. *Journal of Health and Social Behavior, 35*, 193-212.

Verhaeghe, M., Bracke, P., & Bruynooghe, K. (2008). Stigmatization and self-esteem of persons in recovery from mental illness: The role of peer support. *International Journal of Social Psychiatry, 54*(3), 206-218.

Wright, E. R., Gronfein, W., & Owens, T. J. (2000). Deinstitutionalization, social rejection, and the self-esteem of former mental patients. *Journal of Health and Social Behavior, 41*, 68-90.

Young, S. L., & Ensing, D. (1999). Exploring recovery from the perspective of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 22*(3), 219-231.

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment, 52*(1), 30-41.

Direct reprint requests to:

Deborah L. Conrad-Garrisi, RN, PhD, LLP
Wayne State University
875 Anita Ave.
Grosse Pointe Woods, MI
e-mail: Debgarrisi@wayne.edu